DOCUMENT RESUME

ED 369 223 EC 302 953

AUTHOR	Cox, Gary C.
TITLE	An Integrated Children's Mental Health System: Coordinating the Needs of Children with Multiple Problems: Children's Integrated Fund Task Force Report to the Minnesota Legislature..
INSTITUTION	Minnesota State Dept. of Human Services, St. Paul.
PUB DATE	Feb 93
NOTE	122p.; For the preliminary report, see EC 302 952. Appendix E will not reproduce well.
PUB TYPE	Viewpoints (Opinion/Position Papers, Essays, etc.) (120) -- Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Behavior Disorders; Community Programs; Cooperative Programs; *Delivery Systems; *Emotional Disturbances; *Financial Support; Integrated Activities; *Mental Health Programs; Public Policy; State Legislation; *State Programs
IDENTIFIERS	*Minnesota

ABSTRACT

This report proposes creation of a flexible and coordinated system for delivery of comprehensive community-based services to Minnesota children with emotional and behavioral disorders. The proposal calls for the state to support multiagency Local Collaboratives with: (1) legislation that grants local communities certain powers in exchange for commitments and accountability, (2) technical assistance, (3) coordination of state medical programs, and (4) coordination of state departments. Local Collaboratives should eventually include the county agencies for mental health, child welfare/protection, health, and juvenile court services, along with schools, providers, and insurers. The proposed system is functionally integrated, involving multiagency intake by parent and professional collaboration, multiagency assessment coordination, multiagency care planning, unitary case management, and customized services. A locally integrated funding strategy is proposed to enhance the efficiency of existing dollars and leverage significant new dollars through federal reimbursement to fund the expansion of earlier identification and intervention capabilities. The role of managed care in mental health services is also discussed. Appendices contain data on funding needs and expenditures, target population criteria, funding approaches, task force members, a draft of legislation to implement the proposed mental health system, and a glossary. (Reference notes accompany each section.) (JDD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

EC

930220

ED 369 223

An Integrated Children's Mental Health System:

Coordinating The Needs Of Children With Multiple Problems

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

EC 302952

Children's Integrated Fund Task Force
Report To The Minnesota Legislature

February 1993

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Gary C. Cox

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

This report to the Minnesota Legislature -- recommending reforms to children's mental health systems -- is the companion volume to the May 1991 preliminary analysis, entitled "The Children's Mental Health Integrated Fund". That earlier report described the existing system and identified barriers to effective and efficient service delivery. The two reports, together, present both the problem and a solution to Minnesota's systems for serving children with mental health needs. A third action, a legislative bill which would enact the proposed model, will be introduced to the 1993 Legislature.

The Children's Integrated Fund Task Force
wishes to acknowledge the services of
Minnesota Department of Human Services staff
for task force support and production of this report:

Gary C. Cox, Budget Analysis Division
principal analyst and author
task force staff

Vickie Brandt, Mental Health Division
task force staff

Stephen Smothers, Mental Health Division
graphics and layout
task force staff

444 Lafayette Road
Saint Paul, Minnesota 55155
(612) 297-3933
(612) 296-6244 (fax)

BEST COPY AVAILABLE

Table of Contents

Page

Executive Summary i

Preface 1

I. Overview 3

II. System Design 11

III. Integrated Fund Design 39

IV. Managed Care and Mental Health 57

V. Initiatives That Complement This Proposal 63

Appendix A - Data Update 73

Appendix B - Target Population Criteria 81

Appendix C - Integrated Fund vs. Multiple Checkbook Approach 83

Appendix D - Children's Integrated Fund Task Force Members 85

Appendix E - Legislative Draft 91

Appendix F - Glossary of Terminology 109

Executive Summary

The Children's Integrated Fund Task Force, charged by the Legislature to make recommendations on the feasibility of a children's mental health integrated fund, finds that an Integrated Fund is both feasible and desirable in Minnesota.

The Task Force also finds that an integrated service delivery system, supported by an integrated fund, would greatly resolve the problems identified for the Legislature in the May 1992 analysis of existing systems, *The Children's Mental Health Integrated Fund: A Preliminary Report.*

The Task Force recommends that funding be integrated locally because: (1) local governments and school districts own and control the greatest share of dollars going into children's mental health services; (2) most services are controlled at the local level; (3) flexibility can be enhanced when a local community can tailor its integrated system to its unique needs; (4) a community can undertake an integrated system initiative whenever it is ready; and (5) the model encourages local-state partnership that ensures commitment to reform at both levels.

The proposal requires the state to support multi-agency Local Collaboratives with: (1) legislation that grants local communities certain powers in exchange for commitments and accountability; (2) technical assistance; (3) coordination of state medical programs; (4) coordination of state departments by way of the State Coordinating Council for Children's Mental Health.

A Local Collaborative should eventually include the county agencies for mental health, child welfare/protection, health, and juvenile court services, along with schools, providers, and insurers. To receive state technical assistance and start-up funds, the initial collaborative should include, at minimum, the county, a school district or special education cooperative, and a mental health agency if it is not the county.

The Problem With Children's Mental Health Systems

Our child-serving systems tear children into pieces, then treat the pieces. The problems they try to serve -- emotional disorders, juvenile delinquency, school failure, and family violence -- often have common roots. The forces in children's lives that contribute to an emotional disorder in one child may be manifested in another child as a medical malady, anti-social or violent behavior, abuse, or family trauma.

The same children are clients of several systems which tend to serve a child sequentially. No single discipline can identify the common roots of a child's multiple problems and no single system can access all the types of services that are available throughout all systems. Therefore, no single system is capable of addressing all of the needs of a child and family.

Funding provided for children's mental health services also is fragmented. This fragments provider systems, making both continuity of care and coordination of care virtually impossible.

System Design

The proposed system design is not **structurally integrated**; that is, it does not merge all agencies into a single monolith. Rather, it is **functionally integrated** -- using key "integrative functions" to coordinate the services of independent agencies around the needs of an individual child. It weaves together modern specialized treatment technologies and applies them with the flexibility and holism of the "old-time social worker".

The integrative functions are:

- **multi-agency intake by parent and professional collaboration**: learning the child's needs from the point-of-view of the family and guiding the family through the integrated system;
- **multi-agency assessment coordination**: eliminating redundant clinical assessments and securing assessments that meet the needs of all systems and providing sufficient information for the development of care plans;
- **multi-agency care planning**: developing with parents a plan of care by an interagency team of agencies that are expected to work with the child and/or family;
- **unitary case management**: arranging services across all systems in partnership with the child and parents;
- **customized package of services**: devising a creative and highly individualized combination of services, supports, and activities -- both innovative and traditional -- developed by an interdisciplinary team. Tying the package together are "wrap-around services": those innovative, flexible, and highly individualized services that serve to coordinate and facilitate traditional mental health services.

Maximum local flexibility -- with accountability -- is central to this proposal. The Task Force recommends eventual statewide implementation. Local Collaboratives should be permitted to phase in the local integrated system.

The **Target Population**, upon final implementation, are those children up to age 18 who are in need of mental health services and children at risk of suffering and emotional or behavioral disturbance as evidenced by behavior that affects the child's ability to function in primary aspects of daily living including personal relations, living arrangements, work, school, and recreation, and who can benefit from:

(a) multi-agency service coordination and a Customized Package of Services; or
(b) informal coordination of traditional mental health services on a temporary basis.

Short-term state start-up funds and technical assistance will be necessary to fund the transition to an integrated service delivery system and to initiate the more fiscally-efficient integrated fund and long-term revenue enhancement mechanisms. Local systems also should develop system evaluation and client outcome measures; partnerships with private third-party payers; and interagency data-sharing systems.

Integrated Fund Design

An integrated children's mental health fund is a pool of local, state, and federal resources -- consolidated at the local level -- to accomplish locally-agreed upon service goals for the target population. The fund would help all child-serving systems to serve the mental health needs of their client populations.

The overarching purpose of creating a local Integrated Fund is to support the community's effort to create a better system for delivering mental health services to children. The strategy proposed by the Task Force is two-fold:

First, create a single, local pool of funds from which to pay for all children's mental health services. This increased flexibility is crucial to a worker's ability to arrange services that are based on a child's needs.

Second, create a mechanism that can leverage new federal reimbursements to fund the expansion of earlier identification and intervention capabilities and, thereby, to cut the need for crisis intervention and expensive residential treatment.

Partners in an integrated fund do not give up control of their dollars. Instead, they negotiate their contributions in relation to the work that they, themselves, wish to accomplish. A partner commits to the pool those dollars that it would spend on children whose mental health needs it, alone, cannot meet. A partner retains in its own budget the dollars it needs to serve those children for whom it is the sole service provider.

Partners in an integrated fund should collectively assume responsibility for clients and for the service payment obligations of the respective partners; for example, schools' mandate to pay for services identified in a child's individual education plan (IEP) and counties' liability for Rule 5 residential treatment. Mutual protection of the Collaborative partners is essential for expanding capacity for earlier identification of disorders.

The integrated fund mechanism creates an opportunity to increase federal reimbursement from Medicaid, Title IV-A, and Title IV-B without increases in state or local expenditures. Currently, communities spend large sums of money on children with behavioral or emotional disorders that do not receive federal reimbursement. By pooling these unmatched dollars along with traditional mental health expenditures into an integrated children's mental health fund, the entire pool becomes a mental health pool that is eligible for federal reimbursement.

Mental Health And Managed Care

Managed care is a concept that links fiscal and clinical management to provide negotiated costs and levels of quality. It takes several forms including health maintenance organizations, designated provider networks, pre-paid capitation, managed fee-for-service, utilization review, and case management.

The Integrated Children's Mental Health System is compatible with the managed care concept and it is, in fact, a new managed care model for children's mental health.

The state's current public managed health care programs prohibit the integration of mental health services and the development of comprehensive, multi-agency plans of care. Without an **integrated** children's mental health benefit, **no** effective mental health benefit is provided.

The predominant managed care system -- the Prepaid Medical Assistance Program (PMAP) -- provides AFDC clients with a fragmented list of mental health services that excludes both ends of the service continuum: early identification/intervention and residential treatment. By failing to meet children's needs for early intervention, minor disorders can become crises that result in out-of-home placement in expensive residential treatment facilities. Since PMAP contractors are not liable for payment of residential treatment, these costs are shifted to the public sector.

Only by requiring care managers to be responsible for the entire continuum of mental health services -- as proposed in the Integrated Children's Mental Health System -- are incentives created to provide the types of early intervention that can avert later crises and expensive residential placements.

PMAP also severely restricts a community's ability to draw down additional federal Medicaid reimbursement. Once a child is enrolled in a PMAP, no more federal financial participation can be earned for services provided outside of the PMAP contract, such as residential treatment, wrap-around services, prevention, special education, or juvenile justice services. EPSDT is, practically speaking, lost as an option.

The two approaches to overcoming the deficiencies of PMAP for children who need mental health services are: (1) to revise MA law and PMAP contracts to require the HMO contractors to provide integrated children's mental health services or (2) to remove (or "carve out") the mental health services benefit from managed care contracts and bid it separately as is done with, for example, dental benefits. Either way, care managers must:

- coordinate and provide or contract for the full continuum of children's mental health services;
- participate as a partner in a Local Collaborative in communities where they exist;
- manage a broad range of funding sources to ensure maximum federal reimbursement.

Initiatives That Complement This Proposal

Remarkably complementary reform proposals are emerging across the public sector as child-serving agencies have come to the painful conclusion that they are being overwhelmed by the needs of children and families in distress. Reforms are being proposed in the program areas of child welfare, education, developmental disabilities, and mental health; they include redesigns in service delivery, financing mechanisms, information systems, and revenue enhancement.

Although each of these initiatives began with different populations or different service systems in mind, they were often studying the same children. They found that children's needs often cross system boundaries. As a result, the sharp lines that separate systems and professional disciplines can obstruct efforts to serve children.

If these complementary efforts could be linked, it would be possible to envision an overall strategy to coordinate all public services to children. An even larger scope of integration could then be considered.

State-level initiatives that are complementary to the Integrated Children's Mental Health System proposal and that possess components upon which a strategy of overall children's services integration could be constructed include:

- The Interagency Early Childhood Intervention System;
- The Family Preservation Investment Project (FPIP);
- IMPACT (Integrated Management and Planning Act);
- Managed Health Care;
- The Social Services Information System (SSIS);
- The Consolidated Chemical Dependency Treatment Fund;
- Pew Charitable Trusts grant;
- Action For Children Council (formerly a commission);
- The Governor's Children's Cabinet.

It is not the position of the Children's Integrated Fund Task Force that mental health should serve as the loci for integration efforts. The Task Force suggests, however, that its functionally-integrated service delivery model could be used as a means for child-serving agencies to work in concert around the needs of an individual child without a massive restructuring of all agencies into a giant monolith.

Preface

Before the Minnesota children who are suffering from emotional and behavioral disorders can receive the help they need, each child's community must secure three basic items:

- services to treat the children;
- systems to deliver those services; and
- funding sufficient to meet the needs identified.

The Legislature addressed services when it designed and mandated a comprehensive array of community-based services with the passage in 1989 of the Comprehensive Children's Mental Health Act.

The implementation of the Integrated Children's Mental Health System, as proposed in this report, proposes to create a flexible and coordinated system through which to deliver those services to children.

The integrated funding strategy proposed here can significantly enhance the efficiency of existing dollars and leverage significant new dollars through federal reimbursement. Whether sufficient funding will be generated by the Integrated Fund to bring these better services and better service delivery systems to every Minnesota child who needs them is yet unknown. However, reform -- even when it generates resources -- requires investment to begin.

I.

Overview

Overall Findings and Recommendations

The Children's Integrated Fund Task Force finds that integrated funding used to support an integrated service delivery system would greatly resolve many of the barriers to effective and efficient provision of services to emotionally disturbed children, as identified in the May, 1992, preliminary report to the Legislature: *The Children's Mental Health Integrated Fund.*

The Task Force finds that the establishment of an integrated children's mental health fund is both feasible and desirable in Minnesota.

The Task Force finds that multi-agency pooling of currently expended dollars at the local level, including public and private funds, can leverage greater federal entitlement reimbursements for service system development and reform than would be possible using mental health dollars alone.

The Task Force recommends that local governments, with state government assistance, move aggressively towards development of local multi-agency initiatives to use integrated dollars in order to develop integrated service systems for children. Local initiatives should move incrementally to involve county social services, mental health, court services, and public health agencies along with schools, providers, and insurers.

The Task Force recommends that the state departments of Human Services, Education, Corrections, Health, Jobs and Training, and Commerce plus Minnesota Planning coordinate efforts through the State Coordinating Council to work with Medical Assistance (MA), General Assistance Medical Care (GAMC), MinnesotaCare and other state-funded programs in support of local initiatives.

Purpose And Progress Of The Task Force

A. Legislative Purpose Of The Task Force

The Children's Integrated Fund Task Force was convened in May 1992 by the Department of Human Services in response to legislative mandate [Laws of 1991, Chapter 292, Article 6, Section 57, Subdivision 1] which states, in part:

The commissioner of human services shall convene a task force to study the feasibility of establishing an integrated children's mental health fund...The task force shall examine all possible county, state, and federal sources of funds for children's mental health with a view to designing an integrated children's mental health fund, improving methods of coordinating and maximizing all funding sources, and increasing federal funding...The task force shall submit a final report to the legislature by January 1, 1993, with its findings and recommendations.

B. Description Of The Task Force

Membership of the Task Force was set by the Legislature but demand for participation was strong. In response, membership expanded beyond the mandate and ultimately included 68 members. Legislation said:

The task force shall consist of mental health professionals, county social services personnel, service providers, advocates, and parents of children who have experienced episodes of emotional disturbance. The task force shall also include representatives of the children's mental health subcommittee of the state advisory council and local coordinating councils...The task force shall include the commissioners of education, health, and human services; two members of the senate; and two members of the house of representatives.

Participation included representation from: parents of emotionally disturbed children; juvenile court judges; the Association of Minnesota Counties (AMC); the County Director's Association; county social services; juvenile corrections officer; the Departments of Finance, Corrections, and Commerce; Minnesota Planning; the Action For Children Council; the Department of Human Services divisions of Mental Health, Family and Children's Services, Developmental Disabilities, Chemical Dependency, Health Care Management (medical assistance), and Budget Analysis; Wilmar Regional Treatment Center; Local Coordinating Councils; the Children's Mental Health Subcommittee of the State Advisory Council; private insurance companies; the Legal Aid Society; Family and Children's Services of Minneapolis, the

Wilder Foundation, Washburn Child Guidance Center; the Mental Health Association; the Minnesota Association of Community Mental Health Centers; Minneapolis Way To Grow; Alliance for the Mentally Ill; Western Human Development Center (a community mental health center); Minnesota Society for Child and Adolescent Psychiatry; the Minnesota Nurses Association; Educators of Emotionally Disturbed Children.

C. Process Used By The Task Force

The full **Task Force** determined its guiding principles and set its work course during a two-day retreat in May 1992. The retreat was facilitated by Department of Human Services staff and consultants from the Robert Wood Johnson Foundation, who also presented overviews of other integrated funding projects across the nation. The Task Force met in a second two-day retreat in November to merge design efforts, hammer out recommendations, and resolve remaining debates.

The Task Force established two work teams to conduct its investigation and development work: the **Funding Team** studied national models of funding integration and evaluated the pros and cons of each model relative to its usefulness in the Minnesota context. The **Service Delivery Team** researched service delivery aspects of national models and designed an overall system model to fit Minnesota's political and legal environment. The work teams met bi-weekly for six months, each team selecting two co-chairs. Team members undertook examinations of six to eight national integration models, queried state and national system consultants and funding consultants, gathered considerable counsel from a statewide mental health providers' conference, and made extensive use of Task Force staff for research, analysis, and coordination.

Extensive technical and policy consultation has been conducted with medical assistance and managed health care experts. Initial contacts have been made with representatives of private third-party payer groups in an effort to study their potential for involvement in integrated fund initiatives.

Additionally, Task Force leaders and staff met as a **Steering Committee** to coordinate with related state initiatives including the Children's Cabinet, the Family Preservation Investment Project, the State Coordinating Council, the Managed Care Task Force, and the state Interagency Coordinating Council's Task Force on Interagency Early Childhood Intervention. The committee extended the Task Force network to draw participation from the juvenile court bench and the HMO/insurer community.

A **legislation committee** formed after the second Task Force retreat called for a bill to expedite development of the proposed integrated children's mental health system. It met at least weekly for four months. A working draft, to be introduced into the 1993 Legislative Session, is attached to this report.

D. Products Of The Task Force

The Task Force, in its nine months of work, has engaged in technical, policy, and marketing aspects of developing the children's integrated mental health system proposal, drawing on the expertise of its members, consultants, and staff. Products, both tangible and intangible, include:

- a report to the Legislature
- a legislative proposal
- a service delivery system design
- an integrated funding model
- methodology for medicaid revenue enhancement
- inclusion of mental health managed care provisions into state managed health care recommendations
- coordination of model development with related state-level initiatives
- initiation of relations with insurers and HMOs

E. Task Force Expertise And Its Ongoing Role

The expertise developed by the Children's Integrated Fund Task Force and its staff, as a by-product of its nine-month effort, will be an invaluable resource to the long-term development of service integration in Minnesota.

The Task Force process brought knowledge to Minnesota from the vanguard of national experts and gathered experience from U.S. communities who are engaged in state-of-the-art strategies involving integrated systems. Members talked with state specialists to augment their own substantial knowledge of their respective systems, the Minnesota environment, and the needs of children and families. Thus, they applied both national and state knowledge to a practical design approach. Collectively, the Task Force has an considerable grasp of both the technical and political complexities involved in integrating services and the dollars that fund them.

The Legislature is advised to make continued use of the Task Force.

Overview Of The Problem

Ill-served by systems that are often fragmented, inefficient, and incomplete, these children are at high risk of disability, long-term institutionalization, and incarceration.

- Robert Wood Johnson Foundation -

A. Problem Statement: Fragmentation Of Child-Serving Systems

Our child-serving systems tear children into pieces, then treat the pieces.

We have built systems and professional disciplines around symptoms. The problems our systems try to address -- emotional disorders, juvenile delinquency, school failure, and the kind of family stress that leads to violence and/or removal of a child from the home -- all seem to have common roots.[1]

We call the same problem by different names, depending upon how the child exhibits it. The forces in children's lives that cause an emotional disorder in one child may be manifested in another child as a medical malady, anti-social or violent behavior, abuse, or family trauma.

The high correlations between emotional disorders and delinquency, family problems, and school failure are striking. In Hennepin County, for example, 70 percent of the children on the mental health case load already are adjudicated delinquents; 80 percent have been identified by their schools for special education; and they have had, on average, four to eight previous out-of-home placements.[2]

The truth is that the same children are clients of several systems that look at a child narrowly and have "a tendency to serve them sequentially,"[3] according to a county mental health manager. The services a child receives differ, depending upon which door he or she uses to enter the system. No single discipline can identify the common roots of a child's multiple problems and no single system can access all the types of services that are available throughout all systems. Therefore, no single system is capable of addressing all of a child's needs. Thus each, in turn, fails to mend the child's problems.

If the distinct and independent systems were coordinated in their planning and provision of services to a child, this fragmentation might be overcome; but they are not coordinated.

Fragmentation of the system delays identification of problems until they become severe. A school, for example, may not follow up on early signs of an emotional problem because the child's educational progress has not yet been effected. The child's mother runs hither and yon trying to get someone to help her child, but she is stymied, confused, and ultimately unsuccessful. Years later, when a probation officer reviews a client's records, he is amazed that no one acted on the many signs of brewing trouble. But, even now, the probation officer's job is to control the delinquent's behavior and hold the child accountable for misdeeds, not to engage in psychiatric therapy.

In this way does an early problem become a crisis in the lives of a child and family. In this way, too, does the system push more and more of society's resources toward crisis responses: residential treatment, psychiatric hospitals, and jails.

When early signs of disorder fail to command attention, the disorder escalates in severity. Today, systems are overwhelmed by severely disturbed children and few resources are left for earlier intervention, the stage when a crisis might be averted. Professionals in the field have come to call this dilemma "triage", referring to the military doctor's practice of treating the most seriously wounded soldiers first.

The vast majority of public dollars spent on children's services are expended on hospitalization, institutionalization, and out-of-home placement. It is not unusual for a state to spend over 80 percent of its total resources for children's services on 2 percent of the most troubled population.

Our systems' failure to respond adequately to the child is compounded when, as is frequently the case, the whole family is drawn into or is part of the child's problem. "Since a seriously troubled family usually has members with varied problems and needs," a Columbia University study[4] said, "an agency responding to one member is unlikely to be competent with regard to -- or interested in -- the problems of all the other members. Yet, since success with one member often requires that the entire family undergo system change, the lack of service capacity to be family-oriented and holistic is self-defeating."

The funding provided for children's mental health services is just as fragmented as the service delivery system. Those who are trying to arrange care struggle to match a child's treatment needs (1) with the funding sources that the child is eligible to receive; (2) with the dollars that are eligible to pay for the services the child needs; and (3) with the providers who are eligible to receive the available dollars. These mismatched eligibility criteria fragment provider systems, making both continuity of care and coordination of care virtually impossible. Even when dollars are available, funding fragmentation makes it difficult for a child to receive the appropriate type, level, or quality of care.

A 1991 publication of the Robert Wood Johnson Foundation, concludes the following about children with serious emotional and behavior problems: "Ill-served by systems that are often fragmented, inefficient, and incomplete, these children are at high risk of disability, long-term institutionalization, and incarceration...Youth are passed back and forth among agencies that have a partial, but not comprehensive responsibility for their treatment... Rather than being treated effectively, these children and adolescents are over-processed and their needs so escalate that they must be placed in hospitals and residential treatment centers at great expense. In fact, they and their families might benefit more from individually tailored services -- including early intervention -- provided in their homes, schools, and communities."

B. Barriers To Effective And Efficient Service Delivery

Many barriers exist to the creation of a children's mental health system that provides therapeutically effective treatment in a fiscally efficient manner. Most of those listed here are discussed in detail in the Task Force's preliminary report.[5] Among those identified are:

1) Child-serving systems approach children's needs in fragments, splitting the child into his/her component problems. Children's needs cross over the boundaries of these distinct systems: one system serves psychiatric disorders; another addresses delinquent behavior; a third responds to failure in school; while a fourth treats medical maladies. All ignore that a delinquent child usually has an emotional disorder, frequently is failing in school, and often suffers from some type of developmental or health disorder. They often are the same children. Yet no single professional working with a child can serve all of the needs because the professional does not have access to all program and fiscal resources existing throughout the systems.

2) Schools are reluctant to identify emotional disorders because the federal law very often requires them to pay for treatment. Education's mandate is to address the emotional problems that block a child's educational progress.

3) Seriously disturbed children use most of the resources, leaving little or nothing for prevention and early intervention.

4) Services and qualified professionals are in short supply.

5) Child-serving systems tend not to identified disorders early. As severity increases, treatment costs increase and eventual health is less assured.

6) Funding levels are inadequate to establish necessary community-based services without shifting resources away from residential treatment. Yet a wholesale reallocation of resources would amount to abandonment of many of the most severely disturbed children.

7) Funding structures consist in large part of categorical grants subject to eligibility criteria that make it difficult to match clients with dollars to pay for the type of services they need. Created to overcome a funding shortage, categorical grants address some service needs, but tend to decrease the overall financial flexibility.

8) The "least restrictive setting" mandate can be misapplied which can limit

treatment options for children who need intensive intervention immediately. Many counties and courts have interpreted the law to require services to progress step-by-step starting at the least intensive.

9) As a result of system fragmentation, private payers shift costs to public agencies and public payers shift costs to other public agencies.

10) Mandatory procedures for local coordination divert resources from local efforts. Many communities operate with effective informal networks. Mandated, process-oriented formal coordination procedures duplicate local initiatives.

11) State agencies' missions are narrowly defined to address separate fragments of a child's total needs.

12) Coordination and advisory bodies set up to address the issue of interagency coordination have not coordinated their own efforts, many of which are duplicative.

13) The "conduct disorder" label is used to exclude children from mental health treatment and EBD services and dump them into the corrections system.

14) Local actions will determine how well proposed system reforms work. The ability of the state to control change is limited, particularly with regard to interagency coordination.

15) State efforts to plug the gaps in the children's mental health service continuum by creating narrow, categorical programs and funding sources contributes to the fragmentation of the system and often works at cross purposes with stated policy goals.

Section Notes

1. See *A Report on Special Populations*, Minnesota Department of Education, August 1991; cited in *The Children's Mental Health Integrated Fund: A Preliminary Report*, Minnesota Department of Human Services, May 1992, p. 87.

2. Dr. David Sanders, Manager, Family and Children's Mental Health Program, Hennepin County, in testimony to the Minnesota Senate Health Care Committee, February 11, 1993.

3. David Sanders, *op. cit.*

4. See *Integrating Services Integration: An Overview of Initiatives, Issues, and Possibilities*, Alfred J. Kahn and Sheila B. Kamerman, Cross-National Studies Research Program, Columbia University School of Social Work, for the National Center for Children in Poverty, Columbia School of Public Health, September 1992, p. 5.

5. *op. cit.*, *The Children's Mental Health Integrated Fund*, particularly Section IV., pp 69-84.

II.

System Design

Overview Of The Integrated Service Delivery System

In describing the Task Force's vision of an "integrated children's service delivery system", it is important to define our particular concept of "integration."

The proposed system **is not structurally integrated**: that is, it does not seek to merge all child-serving agencies into a single monolith.

Rather, it **is functionally integrated**: several coordinating functions (what will be defined later in this section as "integrative functions") are used to weave together the historically evolved service missions and specialized treatment technologies of the various professionals into a network that functions as a whole.

Functional integration is the natural next step in the evolution of service delivery systems. In discussing what is wrong with the current way our institutions serve children, members of the Task Force have been heard to lament the loss of the "old time social worker" with the unrestricted ability to respond to whatever needs the client might present. Over time, that approach evolved into the specialized technologies that have the ability to more intensively investigate and treat a specific problem but that, unfortunately, tend to split a client into his or her component problems.

This next evolutionary step is a synthesis where modern specialized technologies will be applied with the old-time flexibility and holism.

This functionally-integrated model can be applied in two approaches. First, the Local Collaborative can develop an entity that performs only the coordinating functions and contracts for services from a network of independent providers. Second, the Local Collaborative can designate or create a single entity that would both perform the coordinating functions and provide the full array of services -- such as a community mental health center, a health maintenance organization (HMO), or a private managed care organization.

In the first approach, the care management entity is not a service provider, but operates between the various systems (e.g. education, juvenile justice, and child welfare) to coordinate their services. It does not recreate systems but it recreates the interrelationships among systems. Its provider network can consist of the entire community of fee-for-service vendors or the care management entity can establish a "preferred provider network" in which a select group of providers receive all of the Collaborative's contracts in exchange for providing an agreed-upon service quality and/or a pre-arranged price.

This first approach, while developed by the Task Force to provide children's mental health services to a defined target population, could be applied in an expanded manner to coordinate all types of children's services for all children in a community without forcing the community into a potentially divisive and fruitless political struggle to create a monolithic, all-encompassing children's agency.

The second approach -- while still not creating a monolithic child-serving agency -- does create the administrative integration of all children's mental health service providers under a single entity. This approach, in turn, could be used in two ways. First, in a county with a Pre-paid Medical Assistance Program (PMAP) (a mandatory HMO-type health care program for AFDC clients) provider contracts could be revised to include responsibility for the coordinating functions and for the full array of children's mental health services as well as primary medical services. Second, mental health services could be managed by a single-entity provider separately from primary medical care in a county with no PMAP or with a desire to manage mental health separately from primary medical care. [For further discussion of "managed care", see *Section IV., Managed Care and Mental Health.*]

These new interrelationships are the key to augmenting the system's capability for early identification and intervention. Players such as schools who are in a position to identify potential mental health needs, should no longer fear the full financial burden of treating disorders they identify because responsibility is shared through the integrated fund. Likewise, HMO pediatricians would have a resource to which to make referrals for assessment.

Maximum local flexibility is central to the design of the integrated children's service delivery system. At the same time, the proposal calls for statewide implementation in order to ensure equal service access for all children. System standards mandate **what** broad functions all local systems must be able to perform while allowing communities to determine **how** to do it.

The themes of "local initiative" and "flexibility-with-accountability" have suffused the work of the Task Force. System standards and the Client Pathway Chart outline broad parameters of an integrated service system, but leave many decisions to the Local Collaboratives, acknowledging the diversity and the unique histories of Minnesota communities.

Local Collaboratives will require time for planning and decision-making in a number of complex areas including selection of the initial target population and catchment area, identification of key players and funding streams to be integrated, and development of governance structure. Considerable technical assistance from both state staff and outside experts must be made available to assist Local Collaboratives.

The Local Process Of Change

Each community in each state must struggle to find its own unique way through the maze of system change and service integration. States and communities must work together to assure that each plays a supportive role to the other. Integrative systems change projects must be flexible...When an initial strategy fails, another should be tried, then another, and so on, until the job is done.

Ira S. Lourie, M.D.[1]

Members and staff of the Children's Integrated Fund Task Force have labored for a year of long hours and grueling discussions to devise an integrated children's mental health system and an integrated fund. Yet the work of reforming systems to better serve children has only just begun and most of it will fall to local communities.

It is critical that local leaders view such fundamental change as is proposed here to be a long-term process. Traditionally, Minnesota policymakers have tended to think about systems change in terms of demonstration projects which take three to five years to complete. An integrated children's mental health system is not a demonstration project. "Within this time frame, a newly conceived process can only be started," according to Dr. Lourie.[2]

The models and strategies proposed by the Task Force's are guideposts to help local communities navigate reform. They are not "the answer", but merely stepping stones.

The time commitment, however, will not be the most difficult aspect of creating an integrated fund. Coordinating services to children across agencies requires breaking down the barriers that now prevent coordination. Breaking down those barriers will "require the individuals who direct those agencies to give away...power -- a process that is antithetical to how they got that power in the first place," Dr. Lourie says. Yet "many political individuals have made the choice to 'give away' and have become major forces in system change...and have learned that one can actually gain power by first sharing it."[3]

While the reform must occur at the local level, the state will play an important role: the Legislature by creating legal opportunity; state staff and the Task Force by providing technical assistance.

State policymakers tend to focus on special populations which can inspire issues around which to build policy initiatives and public support, while local leaders are more concerned with the general public and prevention issues. "State and local strategies need not be identical," Dr. Lourie says. "They need only to be compatible."[4]

Findings And Recommendations On System Design

A. Key Findings On System Design

- The needs of children with emotional and behavioral problems cross categorical service boundaries. On the street, it is difficult to distinguish a mental health client from a protection client or a special education client or a court services client.

- The ultimate goal of service integration is to improve the lives of children and their families; system improvement is a means to that end.

- A child entering public systems must, early on, encounter a decision-maker who has access to all program options and all funds necessary to pay for any combination of services needed by the child and family. Such a cross-system perspective is necessary to determine the child's needs, minimize disruption to families, and determine the most appropriate services.

- System integration can reduce the administrative inefficiency and the inequities caused by trying to match a child's needs with fund, service, and provider eligibility criteria. The frequent inability to match a child's needs with eligibility criteria can prevent the childfrom receiving timely and appropriate help.

- The goal of a child-serving system is to provide the most beneficial service at the most advantageous moment. Specifically, this means:
  1) to identify a disorder early before it advances to a crisis stage;
  2) to determine service provision on the basis of therapeutic necessity rather than funding eligibility.

B. Key Recommendations For System Design

1. SCOPE OF IMPLEMENTATION

Implementation should be executed on two fronts:

Local Collaboratives should be encouraged in order to phase in implementation and build a replicable base of local expertise.

Multi-county consortiums are encouraged in less-populous areas of the state if needed to achieve economic viability for an integrated fund. State Medical Assistance staff have suggested that a service delivery, or "catchment", area with a population of 70,000 to

120,000 may be the minimum necessary for economic viability. However, this must be determined for each community, with state technical assistance, and the Task Force does not wish to discourage Local Collaboratives that can be developed around a smaller catchment area.

Catchment areas should be defined to take the following criteria into account:

1) racial diversity
2) income diversity
3) urban/rural character
4) community resource availability
5) political compatibility and demonstrated cooperation

A State Agency Compact, operating under the auspices of the State Coordinating Council (SCC) [as defined by the Comprehensive Children's Mental Health Act], should ensure commitment from and coordinate the efforts of the departments of Human Services, Education, Corrections, Health, Jobs and Training, and Commerce as well as Minnesota Planning and the Action For Children Council. The compact should provide regulatory flexibility and technical assistance to Local Children's Mental Health Collaboratives in exchange for implementation of an integrated children mental health system as recommended by the Task Force in this report and according to the clinical and program standards established by the various state agencies. The compact also should work with the Children's Cabinet to develop an interagency information system.

The SCC should be given statutory authority to play this role and sufficient staff commitment from member departments to execute the function.

The SCC should institute a chairmanship that rotates among member commissioners. By fixing leadership with one commissioner at a time, clear accountability is achieved. At the same time, rotating the responsibility encourages broader commitment from all commissioners. In addition, the SCC should coordinate its efforts with the Children's Cabinet.

2. THE TARGET POPULATION

The goal of the Integrated Children's Service System is to benefit a broad population of children in the mental health, education, juvenile justice, child welfare, child protection, public health, private medical, and vocational training systems. The children's integrated fund, by contrast, targets a somewhat narrower subset of those children.

All children with existing or potential mental health service needs will benefit from the development of an integrated service delivery system and should have access to it as needed. The goal of the system is to provide all Minnesota children with equal access to identification and assessment of emotional disorders.

Use of the integrated system should depend upon a child's need. Not all children with mental health service needs will have the same need for multi-agency case planning, unitary case management, or a customized package of services. Those children determined not to need those functions should be served by existing traditional services.

Access to the integrated system should be accorded whenever a service agency, practitioner, or **parent** answers negatively to the question: *Can my services alone meet the mental health needs of this child and family?*

Target Population for the Integrated Fund

The target population for integrated funds are those children up to age 18 who are in need of mental health services and children at risk suffering an emotional or behavioral disturbance as evidenced by behavior that affects the child's ability to function in primary aspects of daily living including personal relations, living arrangements, work, school, and recreation, and who can benefit from:

a) multi-agency service coordination and a Customized Package of Services.

or

b) informal coordination of traditional mental health services on a temporary basis.

A Local Collaborative may include children up to age 21.

The Local Collaborative must identify an initial target population of children who shall be eligible for services in the first phase of the initiative. The initial target population is defined at local discretion according to local priorities, resources, and the willingness of potential players to join the effort. The initial target population recognizes the need to phase-in such fundamental changes as are proposed by the integrated system.

Access to integrated funds must be accorded without regard to public assistance eligibility.

3. PHASE-IN OF LOCAL INTEGRATED SYSTEMS

The Task Force recommends that Local Collaboratives be permitted to phase-in the development of the children's integrated mental health systems with full statewide implementation by December 31, 2001. Initiation of a Local Collaborative is voluntary.

Phase-in is necessary in order to provide, in the short term, maximum flexibility to local communities who wish to begin local integrated system and to ensure, in the long term, an equally high-quality system to all children across the state.

Commencement of local integrated systems will be characterized by an exchange of powers and commitments between state and local governments with both jurisdictions obliged to certain minimum initial standards. The obligation for full implementation of system standards must rest equally upon local and state agencies.

Those standards subject to phased implementation are:

a. Commitment of Enhanced Revenues
Currently, most communities lack the

resources necessary to implement a comprehensive service system. The enhanced federal revenues anticipated as a result of the integrated fund (see Section III) and any future state funding growth must be used toward integrated system development.

b. **Target Population Phase-in**
A Local Collaborative will define an **initial target population**. It may be those children (1) who are of greatest concern to the community, e.g. violent adolescents; (2) who need a type of service that is unavailable in the community, e.g. early intervention services; or (3) whose current services offer the greatest potential for cost savings; e.g. children in out-of-home placement who can be served while living at home with an integrated system in place. Many communities likely will focus on the third example because savings in residential treatment can be used to fund expansion of the target population to those children who need preventative and early intervention services. Ultimately, local systems should be able to implement the full target population defined above.

c. **Local Collaborative Partnership Phase-in**
Integrated services require that the primary child-serving agencies in the community be partner to the children's integrated system. This includes the county mental health, child welfare, child protection, court services, and public health agencies as well as school districts or special education cooperatives, mental health providers, primary care physicians, and private third-party payers.

However, securing commitment from all of these players may not be possible immediately. For the first phase of a local initiative, the Task Force recommends a commitment from, at minimum, the county, a school district, and a county mental health agency (if it is not the county). These players would develop a plan on how they will bring in the other players including: education, mental health, child welfare, child protection, probation/court services, public health, primary care, jobs and training, and private third party payers.

The Task Force recognizes that, in communities with little history of interagency collaboration, even this minimum commitment is significant progress.

d. **The Service Array Phase-in**
Integrated funding and implementation of the integrative functions should encourage the expansion of services in local communities. The Task Force recommends that Local Collaboratives be permitted to phase in new services as the integrated fund produces additional revenues. Services must be consistent with, but not limited to, those defined in the Comprehensive Children's Mental Health Act.

e. **The Catchment Area Phase-in**
The geographic boundaries of a Local Collaborative impacts its economic viability. National consultants and state Medical Assistance staff suggest that, in

each community, there will be some minimum population that will be required to make an integrated funding approach viable.

Many forces conspire against expanding the catchment area, including the mismatch of county and school district boundaries. Negotiations among the local players will be complex and will take time.

4. START-UP FUNDS AND TECHNICAL ASSISTANCE

Some short-term state-level investment will be necessary to fund the transition to an integrated children's mental health system and to initiate the more fiscally-efficient integrated fund and long-term revenue enhancement mechanisms.

Although the Task Force recognizes that Minnesota already has committed substantial sums to child-serving programs, those resources are strained by the overwhelming needs of children and families. To implement fundamental reform by the reallocation of current dollars would require the state to abandon existing needs. As difficult as it will be, given current budget strain, the provision of temporary start-up funds will be less painful.

Technical assistance will be crucial in order to help Local Collaboratives construct the technically and political complex structures necessary for service collaboration, funding integration, and revenue enhancement. While lessons will be learned from the earliest initiatives that can instruct subsequent efforts, each Collaborative likely will fabricate an original design.

Start-up grants and state technical assistance should be geographically distributed across the twelve Economic Development Regions; multi-county Collaboratives could cross regional lines.

5. RESULTS FOR SYSTEMS AND CLIENTS

Accountability with regard to both clients and system performance should be measured in terms of results. Both state and local agencies should be held accountable. The Task Force fully concurs with the movement taking place in the public sector away from process-oriented accountability. Evaluation of outcomes must be built into the system design from the earliest planning stage. Accountability standards should be based on these criteria:

1. Two types of results must be defined prior to implementation and must be considered a vital and integral component of system integration:
    - system evaluation measures;
    - client outcome measures.
2. Both types must be specific, measurable, and enforceable.
3. Outcomes for children and families must be based on state-of-the-art standards to ensure equal access to quality care for all Minnesota children.
4. Systems evaluation measures must give at least equal weight to quality of care as to cost containment.

6. PRIVATE THIRD PARTY PAYERS

Private third party payers such as health maintenance organizations (HMOs) and private insurers should be sought as partners in local integration collaboratives. Local Collaboratives should promote positive incentives to participate; these could include the opportunity to participate in care planning, the potential to use coordination to reduce their costs, and the clarification of responsibilities.

Third party payers who are partners should have a role equal to other partners in developing a client's plan of care.

Private third party payers who are partner to the integrated fund should have no obligation beyond those of the public partners or those obligations negotiated by the partners. In addition, private payers who are partners should be permitted to specify, by enrollment contract, their obligations to a client beyond their integrated fund contribution.

However, applicable private third party resources that are not partner to the integrated fund should be utilized to the greatest extent possible before using integrated fund dollars.

7. INTERAGENCY INFORMATION SYSTEM

Information is crucial to fiscal and program management and to accountability. Policy-makers require valid information before allocating resources. The federal government demands detailed reporting on both categorical and block grants. Advocates demand to know how well their populations are being served. Program administrators must be able to build a case for public support.

The movement for cross-system integration is growing both in and beyond the mental health arena, yet no information system exists that is capable of meeting its needs. Information integration is the neglected corner of the "integration triad" with more efforts focused instead on funding integration and service delivery integration.

This is both a technical and a policy problem. Policy decisions must be made regarding what kind of information we will need to know and at what levels (program, local, state, federal) we will demand to know it. Policy decisions will prescribe the technical problems.

Among the first areas of policy to study must be the state's Data Practices Act. It is in this arena that policymakers will have to balance the need for dissemination of information across systems against the need to ensure clients' privacy. Technical challenges include the current lack of a common client identifier, a so-called "Statewide Master Index", that would allow computers to identify the same clients or service providers when information about them resides in more than one computer.

Service Standards For System Design

In designing the local system of care, the following service standards need to be incorporated:

- Services must be coordinated across traditional categorical systems and agencies (e.g. mental health or education).
- Care must be comprehensive.
- The system must provide equal access to all children based on service need, not on eligibility criteria.
- All funding sources in the system should be available to all clients and all service decision-makers. Providers should be able to draw from a single source of funding without having to mix and match clients and funding sources.
- System development should focus on expanding capabilities for early identification and intervention.
- Resources should be reallocated to the expansion of prevention, early intervention, and community-based services with the focus of services as well as primary management and decision-making responsibility resting at the community level.
- The system should be built upon existing agencies that may include the creation of a new agency by existing independent agencies. Integration will be accomplished by redefining the relationships among agencies.
- The service delivery system should be flexible to meet local needs but be accountable to statewide standards.
- Integrative functions should be created within local systems.
- Each child must have equal access to a state-of-the-art assessment and assessments should be coordinated to eliminate duplication and to provide assessment information to all providers who need it.
- Coordinated plans of care must be developed for each client in partnership with families and should be designed to benefit the whole family. Professionals should listen to parents.
- The system must include a unitary case management function that gives a single actor overall responsibility for coordination of care in each case. The case manager must have access to spending authority to coordinate services across systems.
- Non-traditional "wrap-around" services should be available to meet clients' needs and fill in the gaps between

services specified in the Comprehensive Children's Mental Health Act.

- Parents should have input equal to professionals in care planning for their children.
- Parents need to be able to access multiple-system services from a single point of entry.
- The system should be child-centered and family-focused. Parent involvement must be maintained to the maximum extent possible (unless clinically inappropriate).
- The system should help families to survive, thereby using families' resources to support their children's service needs.
- A broad array of services should be made available and the system should have the capability to build additional capacity into existing services.
- Positive incentives for coordination should be built into the system.
- Residential care should be unconditional. A child is placed in treatment because he or she has a serious problem. A facility should not be permitted to eject the child for displaying the symptoms that caused the placement.
- Care plans should be built on a child's strengths, as well as addressing problem areas.
- A state-local partnership should be developed that defines the role of each and moves toward elimination of distrust.
- Accountability for client results must be maintained.
- The system must provide a rational transition into adult services.
- Information should be integrated across systems and counties.
- Services must be culturally sensitive and appropriate.
- Treatment should be provided in the least restrictive home/community-based setting appropriate to need.
- Managed care, where used, should manage a child and family's care around the needs of the client, rather than simply to limit benefits as a cost control.

Functions Of The Service Delivery System

The Task Force's primary products in system design are these key integrative functions:

- **multi-agency intake by parent/ professional collaboration:** learning the child's needs from the point-of-view of the family and guiding the family through the integrated system;
- **assessment coordination**: eliminating redundant clinical assessments, securing assessments that meet the needs of all systems, and providing sufficient information for development of care plans;
- **multi-agency care planning**: developing plans of care by an interagency team. Care plans are developed cooperatively with parent(s);
- **unitary case management**: arranging services across all systems in partnership with the child and parents;
- **customized package of services**: devising a creative and highly individualized combination of services, supports, and activities -- both innovative and traditional -- to meet the needs of the child and family in multiple life domain areas. They are developed by an interdisciplinary team. They focus on the strengths of the child.

To best describe the operation of the integrated service delivery system, we will follow the client pathway through the multiple functions of the system.

Readers may wish to refer to the Chart labeled "Client Pathway" on page 29, while reading this section. Direct references to the chart will appear in italics. The Client Pathway chart illustrates functions that the system will perform for a child. It does not set out who performs these functions.

[The integrative functions are illustrated in bold-face type on the chart.]

Existing agencies will continue to carry out their unique missions and perform their mandated services. Ira Lourie,[5] a national consultant who reviewed this design, endorsed our approach. In a draft study of communities seeking to integrate their child-serving systems he wrote: "It is vital...for the specialized technologies of the various professionals not to get lost. It is not the specific modalities of intervention that have to be unified, it is the approaches and philosophies that must come together."

A. Access To The Integrated Service System

Agencies and practitioners make referrals to the integrated system when they believe that they alone cannot meet the mental health needs of a child. *[See top row of the Client Pathway chart.*] Existing agencies, practitioners, and parents who find themselves frustrated by their inability to provide what a child needs will have new resources available.

Parents and children can access the system by self-referral. Community outreach programs may wish to channel clients toward the integrated system because its multi-agency intake process would reduce the confusion clients face when trying to decide which categorical agency is most appropriate.

Aside from these procedural criteria, access is primarily determined by definition of the population to be served. "Target population" is discussed on Page 16.

B. Family And Facilitator Collaboration (Intake)

The child and/or parent makes first contact with the integrated system by way of a "Facilitator" who uses her/his knowledge of the system to collaborate with the client as an equal partner to determine how the system may best serve the client's needs. Initial screening occurs at this point and referrals out of the integrated system may be made for those clients who do not require coordinated assessment, interagency case planning, or unitary case management. For those who remain within the integrated system, the Facilitator acts as the client's guide and advocate within the integrated system. *[See Family/Facilitator Collaboration on the Client Pathways chart.]*

The Facilitator determines what conditions exist in the client's life by eliciting a description of the child's problems and needs, along with the family's concerns for its child. The Facilitator also will discuss financial resource issues with the client.

Local systems must develop a crisis response capability. Crisis response has two components: (1) it must be able to expedite clients through the integrated system itself; and (2) it must be able to obtain crisis assistance services in the community. A third component that lies outside the integrated system would be to encourage each categorical system to enhance its own crisis response capabilities.

C. Assessment Coordination

The next step is to discover whether the child has received any type of assessments and to determine whether any additional assessments are needed in order to begin case planning. The purpose of coordinating assessments is to save the child and family from redundant assessments and to ensure that those assessments performed are those that best meet the needs of professionals, parents, and financial managers involved in case planning. *[See "Assessment Coordination" on the Client Pathway chart].*

State-of-the-art assessment standards will be developed in order to ensure equal access for all Minnesota children.

The assessment function could be performed either by an individual or a team. Either way, parents' input should be given equal weight to that of professionals in the assessment coordination process.

Referrals out of the integrated system may be made at this point if the child's only multi-agency need is for assessment coordination.

D. Determine Need For Multi-Agency Coordination

The need for multi-agency coordination depends on the complexity and intensity of the child's needs.

The integrated system is designed to provide multi-agency case coordination on two levels of intensity: (1) for those children who need interagency-team case planning; and (2) for those who need less-intensive and less-formal coordination of categorical services. This distinction is made to allow local systems to balance the child's need against demands upon the system. *[The Client Pathway chart says: "Determine Need For Multi-agency Coordination". For both levels of intensity identified here, the answer is "yes", followed by arrows leading to the next steps.]*

First level: developing an multi-agency plan of care is an intensive team effort. If, for example, a child is delinquent, has experienced failure in school, and requires psychiatric therapy, the demands of interagency case planning are justifiable. The child is involved in multiple systems. The service needs are complex and this is an expensive case.

Interagency case planning is designed to encourage early intervention by relieving those who may identify a problem from the liability of paying for treatment. A school, for example, may be more observant of disorders that don't impact a child's education if the integrated system takes financial responsibility for treatment.

The Integrated Fund, here, would pay for all of the integrative functions and would pay for most services and treatments. However, as will be explained elsewhere, private insurers who are not party to the Integrated Fund would be tapped first and to the greatest extent possible.

Second level: not all children need such high-level intervention; their needs may be met by informal coordination of one or two categorical services with periodic follow-up. This approach maintains the child's link to the integrated system and allows the integrated care managers to immediately shift into more intensive care if the child should experience a severe episode.

Let's say a school social worker detects the signs of depression in a high school student. After assessment, the team feels that regular sessions with a local psychiatrist would meet the girl's immediate needs. However, the team is not confident they have witnessed the end of her problems. By maintaining informal contact with the psychiatrist and following the case, they are prepared to quickly pull her into more intensive intervention should she begin, for example, to talk of suicide. Since care plans must be executed in cooperation with the client's family, the girl's parents act as a check on the system to prevent excessive intervention.

The Integrated Fund would continue to pay for this coordination but, for the most part, would not pay for services, here. However, the Fund could pay for non-traditional, wrap-around services that are not covered by other resources. Additionally, the local integrated system could elect to pay for needed categorical services if no other source were available.

Finally, referrals out of the integrated system can be made at this step if the interagency team determines that the child's mental health needs can be met by a single agency or practitioner. *[The Client Pathway chart shows this as a "no" response.]* Such would be the case if, after assessments were completed, the original referring agency was satisfied that it alone could meet the child's needs. Such also would be the case if the team determined that another agency or practitioner alone could best meet the child's mental health needs or if a parent declined further participation.

The use of Integrated Fund dollars would cease at this point.

[On the Client Pathway chart, the next two steps begin at the "yes" response on the far left of the step "Determine Need For Multi-agency Coordination" and flow down to the grouping of circles at lower-left.]

E. Formal Multi-Agency Plan Of Care

An interagency case planning team, consisting of representatives from the partner agencies, at least one of the child's parents, and the child when feasible, gather to analyze and plan the specific service needs of an individual child and family.

The team carries both clinical services and budget management responsibility but it must permit the child's and family's service needs to drive the system.

The interagency case planning team, collectively, must have spending authority with regard to the Integrated Fund. Team members must have authority to commit the expenditure of any categorical funding sources that the Team plans to use for the child's services. If private insurers or HMOs are partners to the Integrated Fund, it is appropriate that their representatives sit on the case planning team.

These teams act to blend the resources of their partner agencies, but they also act as formal gatekeepers to the most expensive services, such as residential placement.[6]

The methodology proposed here has been used with great success in most communities by Interagency Early Childhood Intervention teams in the development of Individual Family Service Plans (IFSPs).

F. Unitary Case Management For A Customized Package Of Services

Unitary case management is the coordination and brokering of services across agencies and categorical service systems. It is the execution of individual case plans.

Local communities may choose whether this function is best served by an individual case manager or an interagency team. Some communities may wish to develop a new profession of super-case-managers who are competent across all systems. Others may prefer to bring staff's own-system expertise into a team effort and avoid forcing staff to master each others' systems.

A Customized Package of Service suggests, broadly, whatever is necessary to address a child's needs. It is an admixture of traditional categorical services with innovative, non-traditional services and activities. Its scope is not limited to existing services but seeks to invent whatever is necessary. It is not merely a new resource, but a new way of thinking. It encourages planners and case managers to be imaginative.

In the customized-service environment, a case manager draws service resources from the child welfare, school, juvenile court, mental health, medical, and other systems. But these are not the whole of it. The case manager can draw from private and non-profit volunteer programs as well as purchase hard goods or transportation. If the child's home life can be improved by finding a support group for the child's parent, the case manager can provide it. *[The circles at lower-left of the Client Pathway chart illustrate customized services. Note that these are categories of services and activities, not providers.]*

Illustration 1:

An adolescent was thought to need 24-hour monitoring because he occasionally fell into a state of unawareness and wandered off, endangering his safety. For this reason alone he was in residential placement; no other regular treatment was necessary. An imaginative case manager devised a way to bring him home and, at the same time, protect his safety. An electronic bracelet of the type used to monitor the whereabouts of probationers was purchased and the sensors were set up to alert his mother if he wandered beyond his yard.

Illustration 2:

An adolescent boy won't get out of bed in the morning. He has missed so much school that he is being threatened with expulsion and, once it is too late to catch the bus, he wanders out of the house and has begun to hang out with some dangerous types. His single mother is concerned, but her son is very large. When he refuses to get up, there is little she can do. However, the boy's case manager knows how to stop his downward slide -- if only she could find a little flexible money. She would hire a reputable neighborhood man -- also large -- to go to the boy's home each morning to ensure that he is up and running.

It is likely that some clients will need interagency-team case planning yet reject intensive case management. The system can accommodate this by directing such a case from the interagency planning team to the informal service coordinator to facilitate those services that the client desires. *[This is illustrated on the Client Pathway chart by the two-way arrow joining "Multi-Agency Plan" and "Informal Service Coordination".]*

[On the Client Pathway chart, the next two steps begin with the second "yes" response at the center of the "Determine Need For Multi-Agency Coordination" step. Then they flow down to the right toward the arch of boxes at lower-right.]

G. Informal Categorical Service Coordination

Some children may need services from more than one system, but not require intense monitoring and intervention. For these children, a service coordinator can facilitate communication between providers through an informal network of professionals that already is common in many communities.

Such coordination should increase both the therapeutic effectiveness of programs and the efficiency of fiscal resources without the delicate management required in unitary case management.

Additionally, by maintaining the link between the integrated system and the child, the child's changing needs can be better anticipated and response quickened should it become necessary to shift to more intensive intervention for a time.

Informal service coordination can link traditional categorical services such as psychiatric therapy, special education, probation, family preservation, pediatric care, and vocational training. It also can provide -- if this is all a child needs -- the same innovative services and activities that are available to children receiving a customized package of services.

[The Client Pathway chart at lower-right illustrates categorical services and does not attempt to show the broad array of providers.]

H. Appeals, Due Process, And Mediation

Clients in the integrated system retain all rights granted to them under state and federal law. For example, a child who meets criteria for services under federal or state special education laws as a child with "emotional-behavioral disturbance" (EBD) or a child meeting the required definition of "seriously emotionally disturbed" (SED) in the Minnesota Children's Comprehensive Mental Health Act would retain the entitlements and appeal rights within those respective statutory schemes. Where the system with a service-duty to the child is pooling its funding and service resources, it would be able to draw on the resources of other participating systems in providing its statutorily, mandated services.

Illustration:

Chelsea is a 12-year-old 7th grader who meets the definition of "severely emotionally disturbed" child within the meaning of the Minnesota Children's Comprehensive Mental Health Act. Under the Act, the county is mandated to provide to Chelsea day treatment services, among other things. Chelsea's middle school, as part of its special education services, operates a day treatment service for kids labeled EBD. However, her behavioral problems have not manifested

themselves in a way to entitle her to services under the state special education laws. Yet, because Chelsea's service plan under the integrated system includes provision for her to attend the day treatment program, the county's duty to provide that service to her has been met because of their participation in the integrated system.

The Client Pathway chart makes clear that this system anticipates the right of a parent to appeal any decision or to deny, terminate or suspend services at any point in the process. However, the Task Force recommends that communities establish a mediation program that would be available to parents prior to a formal appeal. While this is not required by law , it was the collective belief of the Children's Integrated Fund Task Force that such a mediation process could, in many cases, resolve differences between families and providers regarding needs of the child in a manner that would preclude the considerable expense and delay involved in the administrative appeal process. Where that mediation process fails, the appeal rights already in law would continue to be available to the family. *[See the function labeled "Parent or professional initiated appeal or medication" at the upper left of the Client Pathway chart.]*

No mediation program currently exists for children's mental health cases. A state-established set of standards and network of mediators could facilitate this process. However, communities could establish local processes using mediators that are agreeable to both disputing parties.

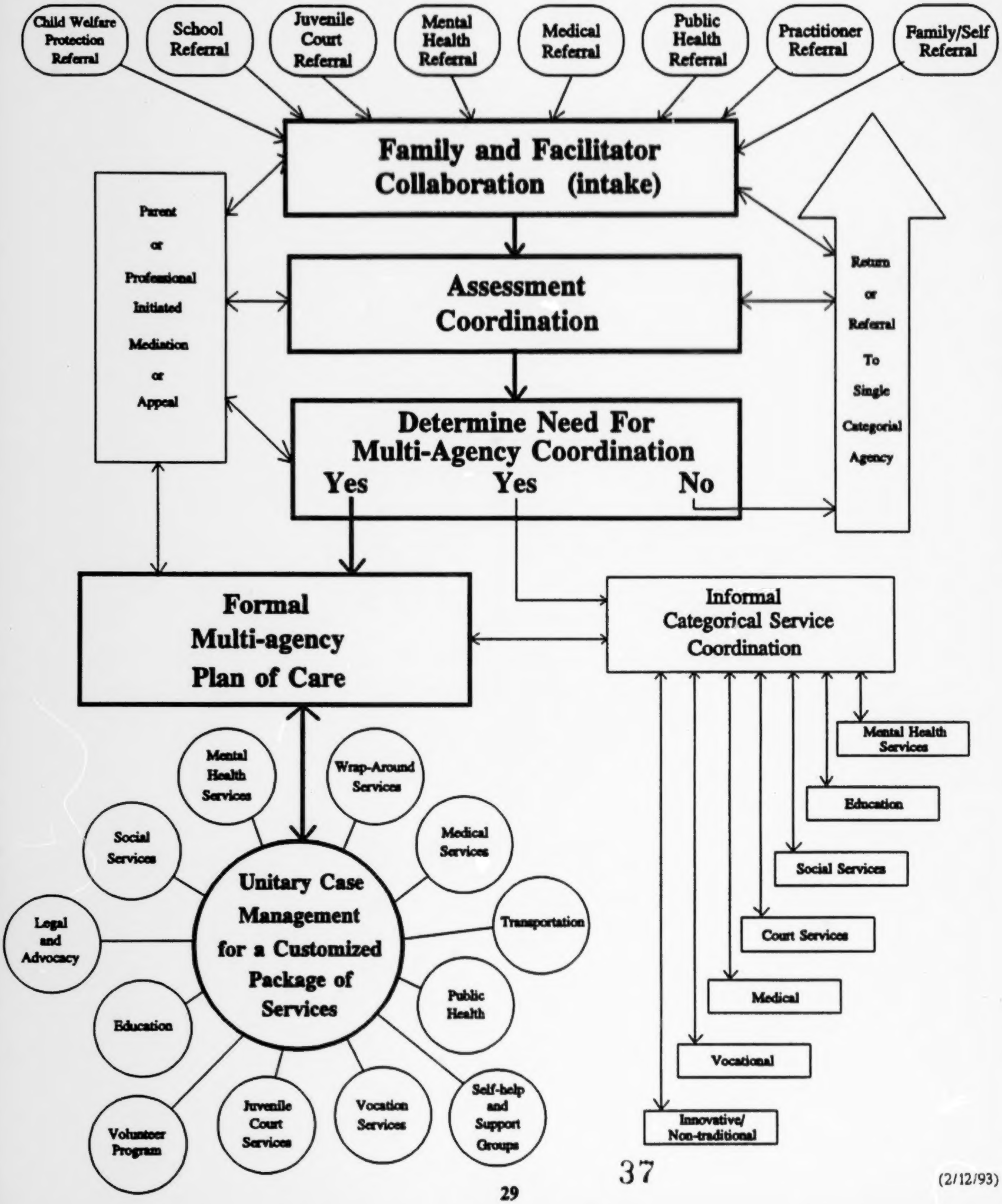
Similarly, CHIPS (Children in Need of Protection or Services) jurisdiction within the juvenile court system would still be available to any professional or other party who believed that the mental health needs of the child were not being met due to the inability or unwillingness of the parent to provide for those needs.

The integrated system proposed here does not abridge the dispositional power of the juvenile court to order whatever mental health services the court believes are required for any given child. However, it is believed that most juvenile court judges would welcome collaborative efforts in assessment, coordination and planning of services around the need of any given child who might come under their jurisdiction. Therefore, regardless of whether a child came to the court by way of abuse, delinquency, or unmet mental health needs, the court would have at its disposal the multi-agency assessment of that child's needs to help make its disposition.

These rights are applicable at any step in the client pathway.

CLIENT PATHWAY

Functions of a Children's Integrated Service System


Child Welfare Protection Referral
School Referral
Juvenile Court Referral
Mental Health Referral
Medical Referral
Public Health Referral
Practitioner Referral
Family/Self Referral
Family and Facilitator Collaboration (intake)
Parent or Professional Initiated Mediation or Appeal
Assessment Coordination
Return or Referral To Single Categorial Agency
Determine Need For Multi-Agency Coordination
Yes
Yes
No
Formal Multi-agency Plan of Care
Informal Categorical Service Coordination
Mental Health Services
Education
Social Services
Court Services
Medical
Vocational
Innovative/ Non-traditional
Unitary Case Management for a Customized Package of Services
Mental Health Services
Wrap-Around Services
Social Services
Medical Services
Legal and Advocacy
Transportation
Education
Public Health
Volunteer Program
Juvenile Court Services
Vocation Services
Self-help and Support Groups

(2/12/93)

Local and State Governance

While creation of integrated governance structures can be an important component of interagency collaboration, governance structures must not become the primary path to reform. Governance should be viewed, instead, as a means to institutionalize reforms achieved in client care.

"In order for a local system change effort to proceed," concluded national consultant Ira Lourie in a study[7] of local systems change efforts, "some form of governance must be established. This concretization of the community change is vital to assuring that the new look of the system not be dismantled. The forces of inertia are always moving to impede and/or overturn integrative service-based system change and the functioning governance can be a major force in overcoming that inertia."

Still, governance structures should be viewed as dynamic, changing as needs change. At the local level, change will be experienced among the Collaborative partners and they will make changes to their budgets and policies as a community moves beyond its first tentative steps to full implementation of an integrated children's system.

At the state level, where the purpose of governance is to make Local Collaboratives work, it is inevitable that relationships and needs will change as the experience of the vanguard communities spreads across Minnesota. "It should not be assumed," according to a Pew Charitable Trusts report[8], "that the governance structure elected for the start...need necessarily be the governance option in place when the implementation is at scale" (i.e. full statewide implementation).

Since the system design requires an active partnership between local and state players, governance must include both local and state components.

A. Local System Governance

Governance of a local integrated children's system should be primarily in the hands of local participants, dictated by local needs and local dynamics, but responsible to statewide standards that ensure all Minnesota children with or at risk of emotional or behavioral disturbance equal access to integrated services.

Members of the Children's Integrated Fund Task Force have held as one of their key tenets that local communities are best able to structure their resources so as to achieve the statewide standards set forth in the system design. The Task Force believes the strategy proposed has struck the best possible balance between statewide implementation and local flexibility.

National innovators of child-serving systems have reached the same conclusion. The Pew study[9] told administrators of its "Children's Initiative" grants: "It is recommended that the Initiative not dictate a particular form of governance but instead require certain core and highly recommended elements, allowing potential sites to adapt a model to their own setting."

Governance of the Local Collaborative, then, should build administrative structures according to community needs on a foundation of statewide performance standards.

LOCAL GOVERNANCE FUNCTIONS

Governance is the legal partnership created by the existing local players. It holds the legal authority to pool resources and operate an integrated service delivery system.

The local players who come together to create an integrated system may designate one among them as the governance authority or they may legally establish a new children's mental health authority.

The governance authority must designate a care management entity, a role it may serve itself or grant to another body.

The children's mental health care management entity performs the core integrative functions, which are the basis for service coordination, and manages the provision care, including the full array of children's mental health services.

The care management entity may be an interagency body, drawing staff from the partner agencies, or it may be a contractor such as a community mental health center, a health maintenance organization (HMO), or a managed mental health care enterprise (often referred to as a "carve-out company").

In order to help distinguish governance from care management, their primary functions are summarized below.

The Governance Authority:

- creates the partnership among the players
- acts as fiscal agent to the state for Medical Assistance and the enhanced revenues
- oversees the management of integrated fund and enhanced federal dollars returned from the state special revenue fund
- designates the Managed Children's Mental Health Care Entity
- [if care management is contracted] oversees fiscal and clinical management; system and client measures; data collection and reporting;

Care Management Entity,
  if it is an interagency public or quasi public entity:
  - performs the Integrative Functions for children's mental health services
    and
  - contracts for service provision
  - manages entity personnel
  - sets system performance & client outcome standards
  - evaluates fiscal and clinical performance

- reviews data collection and reports to state;

if it is a private contractor:

- performs the Integrative Functions for children's mental health services
  and
- provides or sub-contracts service provision
- manages contractor personnel
- manages fiscal resources and clinical responsibility
- measures system performance & client outcome
- collects data and manages information flow to local governance (partners) and state

LOCAL GOVERNANCE STRUCTURE OPTIONS

The Task Force recommends setting geographic boundaries for the Local Collaborative by county or multi-county lines. This would promote the state-local partnership because most systems likely to be involved in the local partnership relate to the state through counties.

Multi-county boundaries should be set when necessary to improve service integration or create an economically viable catchment area, as will be described later.

Administrative structure also should be a local option, based on local resources and needs. That choice would, of course, be influenced by the community's goals; nevertheless, other states' experience indicates that existing conditions are a powerful influence. Local efforts should take into account the structure of existing institutions, their history of collaboration, and the personalities within those institutions.

Option for administrative structure include:

- An autonomous children's authority governed by representatives of the partner agencies. This would be a new organization. It would likely draw existing staff from it partner agencies and be responsible for operating the integrative functions of the system, not direct service provision. A few local children's authorities have been granted independent taxing powers.

- An interagency management team whose members answer to their respective agencies.

- A joint-powers agreement: a contract between two or more governments (e.g. two counties or a county and a school district) for the joint planning, financing, and delivery of services to the inhabitants of all participating jurisdictions.[10]

- Intergovernmental service contract: an agreement between two governmental units in which one pays the other for the delivery of a particular service.[11]

- Intergovernmental service transfer: the permanent transfer of total responsibility for the provision of a service from one governmental unit to another.[12]

- Contract with a private managed care

organization. Private, independent managed care enterprises are proliferating nationwide and are said to be eager to contract with well-designed public integrated systems. Counties already involved with prepaid medical assistance plans may want to expand capitation rates to include the full array of children's mental health services or to split off mental health services from existing contracts. [Managed care options are further discussed in Section IV.]

- In the initial phases of integration, communities may find it easier to collaborate using a "multiple checkbook" approach in which no new administrative structure is created. Here, the partner agencies appoint representatives with spending authority to plan services and negotiate the apportionment of service costs among themselves on a case-by-case basis. Final implementation should aim at a fully integrated (pooled) fund.

The Task Force's approach finds endorsement in the Pew[13] report on governance. That report strongly endorsed mandated collaboration among local agencies as a way to improve the outcomes for children that move among them. This concept is consistent with the Task Force's recommendation for statewide establishment of integrative functions, while leaving local communities to structure their own organizational relationships. The Pew report also endorsed the creation of new parallel or supplementary children's authorities -- possibly with independent interagency managers or independent taxing powers -- to perform integrative functions. Such an autonomous children's authority should not be involved in direct service provision, the report said, but concentrate on those functions that make service providers work together.

The report opposed (a) mandating formal merger of existing child-serving agencies into a single monolithic organization. It pointed out, however, that such a merger could force the elimination of turf boundaries and offer a chance to overturn unwanted past practices. The report also opposed (b) relying on voluntary collaboration that is vulnerable to political whim; instead it said integrative functions should be formalized and mandatory. Finally, it opposed (c) reliance on existing agencies alone as the vehicle for reform.

STATEWIDE STANDARDS FOR LOCAL GOVERNANCE

Governance standards in the Task Force design are meant to help ensure that Local Collaboratives will develop the capabilities necessary to succeed and to help ensure equitable care for all children across the state.

Capabilities Of A Local Governance Structure

The governance structure for a local integrated service delivery system must be able to:

1. achieve system and funding integration
2. administer interagency personnel

3. enforce system standards
4. gain control of existing resources and provide financial management
5. provide sophisticated, flexible resource management for quick resource reallocation to meet client needs
6 enhance federal revenue and retain the proceeds
7. resolve interagency, interjurisdictional, and interdisciplinary disputes
8. provide for client involvement in decision-making and resolve disputes between clients and the system
9. provide a formal role for private third-party payers
10. plan for future needs
11. provide interagency data exchange
12. collect service data, enforce data standards, and fulfill reporting mandates
13. evaluate system performance and client outcomes
14. recruit staff and provide training
15. advocate for children and families and influence local policy
16. provide continuity of leadership
17. provide outreach, disseminate public information, and sustain public confidence

Catchment Area

The geographic area to be served must be based upon an economically viable minimum population that depends, in turn, on the target population to be served. In many parts of the state, economic viability may indicate multi-county systems.

Administering the integrated functions, as well as planning and fully implementing the system will result in some fixed or highly inflexible costs. Developing the necessary array of services also will add cost. These costs must be spread over a population that is large enough to cover the costs by available per-client revenues.

Economic viability is a particularly acute issue in any system which chooses to manage mental health care via a pre-paid capitated financial scheme where a management entity must cover all service obligations out of revenues received for each individual covered by the plan. The covered population must include sufficient numbers of inexpensive clients to cover the cost of the expensive clients, such as those children who require out-of-home placement.

Exactly what economic viability means must be determined by local and state technical assistance efforts. However, state Medical Assistance staff suggest that a catchment area of 70,000 to 120,000 population would be viable for federal revenue enhancement and medical assistance waiver purposes.

Regional Distribution Of Local Collaboratives

The Task Force recommends that state technical assistance and any state start-up funds be distributed to Local Collaboratives proportionately across the state's 12 Economic Development Regions. Multi-county Collaboratives would be permitted to cross regional lines and, for distribution purposes, would be recognized as Collaboratives for all regions involved.

Fully Integrated Funding

The final phase of fiscal implementation must be a locally integrated fund, a pooling of multi-system local, state, and federal dollars into a single source of dollars to provide coordinated mental health services to the target population.

The contrasting "multiple checkbook" approach -- whereby representatives of the various systems come to service-coordination meetings with spending authority and distribute the payment burden among themselves on a case-by-case basis -- retains substantial distance between agencies and was determined not to best satisfy the Task Force's primary goals for an integrated system.

However, local communities are free to use the multiple checkbook approach, or other innovations, in the initial efforts of a multi-phase initiative where it may ease the transition to full funding integration.

B. State System Governance

State-level governance should focus on goals, not administrative structure.

Two key points must be made about state participation in a partnership aimed at children's services integration: First, state participation is crucial. Second, the structure of that participation is not as important as the goals and attitudes that guide it.

The role of the state-level partner is to enable and support local-level service and funding integration. In the short view, this means that the state governance structure must be able to set the stage for Local Collaboratives with legislative changes, regulatory flexibility, creation of interdisciplinary standards, and technical assistance. In the long view, it means that state governance must be structured to simultaneously move toward statewide implementation.

Several governance structure options available to the state will be discussed below. However, the Task Force has not determined that one strategy would be greatly superior to another. Further, the Task Force is reluctant to urge supporters of integration to expend precious political capital on what would surely become a highly charged, but ultimately distracting, debate on governance structure.

Many structures could achieve advantages for integration; none would come without tradeoffs. For example, an often-heard proposal to create a "children's department" which would consolidate all state-level public programs and funds serving children under a single administration, has great potential for children's service integration. However, the price of forging these links among child-serving systems would be the severance of existing links within program areas such as mental health systems that serve both adults and children. Children grow up. So, during that interval of their lives in which they are making the transition to adulthood, links between child and adult systems are as important to them as the coordination of day-to-day services.

The goal of state-level integration is to create institutional and personal collaboration among the child-serving departments in order to implement changes in rule and law and to provide the technical assistance necessary to support local integration.

STATE-LEVEL GOVERNANCE STRUCTURE OPTIONS INCLUDE:

Collaboration among existing agencies

> The Governor or the Legislature could appoint a permanent interagency body to manage the integration of children's service delivery and funding. The existing State Coordinating Council, consisting of the commissioners of child-serving state departments or their representatives, could be given the authority and resources to manage this responsibility.
>
> The Children's Cabinet and Sub-Cabinet could expand their current focus on state agency children's budgets to include budget and policy support for local integrated service delivery, including the coordination of policymaking and planning efforts.
>
> The Governor or the Legislature could establish a time-limited interdisciplinary project team -- that could be composed of active Task Force members -- with the specific task of developing and implementing the Task Force recommendations and providing technical assistance to Local Collaboratives.

Collaboration to establish a new parallel or supplemental agency

> A new office for children and families not formed from existing agencies could be empowered for development, implementation, and technical assistance. This could be engendered from the Governor's Action For Children Council with a specific mandate for children's mental health integration.
>
> A centralized data office could collect fiscal and program data from local integrated children's systems and process both management information reports and federally mandated reports. It could advise and provide technical assistance to communities on complex interagency data sharing issues. It could set data standards and advise the Medical Assistance Management Information System (MMIS) on policy issues related to mental health MA billings.
>
> A joint training and recruiting office using pooled funds could channel personnel competent in cross-system functions to local communities.
>
> A new superagency could be created with line authority over existing state departments.
>
> The Children's Integrated Fund Task Force could be continued or reconstituted to continue system design work or to advise state staff and monitor implementation.

Section Notes

1. See Ira S. Lourie, M.D., *Development of Local Systems of Care*, Human Service Collaborative, Washington, D.C., June 15, 1992, p. 1.

2. *ibid.*, p. 6.

3. *ibid.*, p. 11.

4. *ibid.*, p. 17.

5. *ibid.*, p. 11.

6. *ibid.*, p. 21.

7. *ibid.*

8. Elizabeth C. Reveal, *Governance Options For The Children's Initiative: Making Systems Work*, The Pew Charitable Trusts, June 1991, p. 26.

9. *ibid.*, p. iii.

10. Cathy E. Gustafson, *The Power Of Partnership: a guide to intergovernmental agreements*, Hamline University Graduate Program of Public Administration, June 1992, p. 5.

11. *ibid.*

12. *ibid.*

13. Reveal, *op. cit.*, pp. iii, 28.

III.
Integrated Fund Design

Overview of Integrated Funding

The overarching purpose of creating a local integrated fund, with all of its inherent technical and political complexities, is to support the community's effort to create a better system for delivering services to children. An integrated funding strategy is a means to broader system reform.

The strategy proposed by the Task Force is twofold: first, to redirect current spending patterns and, second, to maximize federal entitlement reimbursement.

The goal behind redirecting current spending is to simplify the struggle faced by service decision-makers who are trying to find dollars to buy services for needy children and to increase the flexibility of those dollars. The fiscal inflexibility of the current funding structures means that children cannot get the preventative services they need to avoid a crisis while, at the same time, dollars are readily available to pay for crisis care after a problem has exploded.

The goal behind maximizing federal reimbursement is to fund the expansion of earlier identification and intervention capabilities within the children's mental health system and, thereby, to fund the transition to a front-end, community-based service delivery system where preventative services can reduce the over-reliance on more intensive and expensive treatment once problems become more severe. Expanded federal funds likely will be the primary source of new dollars going into children's mental health in the near future.

A. Definition Of A Local Integrated Children's Mental Health Fund

An integrated children's mental health fund is a pool of local and state resources, consolidated at the local level, to accomplish locally agreed upon service goals for the target population. The fund can help all child-serving systems to serve the mental health needs of children among their populations.

A integrated fund is a **structure** or strategy and should be recognized as distinct from the funding **level**. In itself, an integrated fund is revenue neutral to both local and state governments.

Federal revenue enhancement mechanisms ensure that the fund will not be neutral to the federal government, however. The model permits expenditures made by non-mental health systems for children who are emotionally or behaviorally disturbed to be designated as mental health services and to leverage additional federal medical assistance reimbursement against the pooled funds.

Partners in the integrated fund should ultimately include:

- county or multiple-county child welfare/child protection agencies;
- school districts and/or special education cooperatives;
- juvenile court services or community corrections agencies;
- public health agencies;
- mental health agencies;
- job training agencies;
- private insurers and health maintenance organizations.

Every effort should be made to enlist the support of juvenile court judges who historically have tremendous control over the expenditure of county service dollars. The integrated fund has no authority to control the judges' dispositional authority; however it is hoped that judges would carefully consider multi-agency care plans.

It must be clear that the Task Force is proposing a **mental health** integrated fund for a broad, but specific, target population. It is not proposing an overall fund[1] that would pay for all services for all children. Neither is it advocating the fragmented financial structure of the status quo. Rather, its proposal hits the middle ground: the integration of all dollars from all child-serving systems that can be used to address the emotional or behavioral disorders of each system's clients.

B. Phase-In Of Integrated Funding

Phase-in is key to providing local communities with the flexibility needed to initiate collaboration. Although Local Collaboratives aim for eventual implementation of all integrated fund standards, a multi-phase approach should be permitted in two areas:

1. The phase-in of Collaborative partners recognizes that active collaboration between even two agencies must be considered substantial progress in many communities. In order to receive state start-up funds and technical assistance, the initial, first-phase initiative must include, at minimum, the county, one school district or special education coop, and the mental health agency if it is not the county.

2. The phase-in of a distinct and formally integrated multi-agency funding pool recognizes that cooperation and trust must build slowly. In the meantime, a "multiple check" approach would permit partners to come to the table to discuss what they want to accomplish and negotiate who pays for what.

Findings And Conclusions From National Models

A. Key Findings On Integrated Funding

The Task Force investigated several state-of-the-art integrated funding models that have been developed in other states with the advice of national experts and foundation grants. Thus, Minnesota has benefitted from the most current thinking in the nation. The "key findings" highlight what Minnesota can expect from integrated funding.

- Integrated funding and revenue enhancement is an important incentive that has resulted in better coordination of services, more collaborative working relationships and, in each site studied, has resulted in improvements in the local service delivery system. These improvements have resulted without regard to whether the system changes were initiated by the local community or the state.

- Service decision-makers are able to draw from a single funding source so that dollars can follow clients on the basis of need rather than forcing decision-makers to play a shell game of matching eligibility criteria for clients, funding, services, and providers.

- Multi-agency pooling of currently expended dollars, including public and private funds, can leverage greater federal entitlement reimbursements for service system development and reform than would be possible using mental health dollars alone.

- Integrated funding, in a number of national demonstrations, has resulted in the shift of expenditures from high-cost residential care, with decreased utilization of out-of-home placement, and to the development of flexible arrays of community-based services.

- An integrated financing system permits enough flexibility to create individualized, multi-agency service plans that wrap services around the need of a particular child and family and provide continuity of care over time.

B. Benefits Of Integrated Funding Experienced In Other States

Investigation, by the Task Force, of integrated funding models being tried in other states identified several benefits that also could be expected from the creation of integrated funding in Minnesota:

- Integrated funding will support integrated services and be responsive to clients involved in multiple systems.

- Integrated funding will create sufficient fiscal flexibility to provide any necessary service to any child in need.

- Integrated funding will provide more effective use of existing resources and more efficient use of taxpayers' dollars.

- Integrated funding promotes equal access to services for all children.

- Integrated funding promotes provision of the most appropriate service, matched to client need.

- Integrated funding promotes a community-based service system that keeps local dollars in the community.

- Integrated funding permits the use of Medical Assistance dollars for services to eligible children in schools.

C. Task Force Conclusions About The Minnesota Environment

After studying national models and consulting with experts, the Task Force took a serious look at Minnesota's political and legal environment and reached these key conclusions:

- A critical window of opportunity currently exists for the implementation of an integrated system while (1) uncapped federal Medicaid and IV-E dollars are still available; (2) state health care reform is not finalized; and (3) major national health care reform is expected.

- A number of local communities are ripe for integrated funding. They are conducting integration activities and are interested in testing models.

- A statewide integrated funding strategy is necessary to give all children equal opportunity for adequate care.

- An integrated system can be revenue neutral to state and local governments.

- Funding structures and funding levels are distinct barriers to serving children. An integrated funding structure should not be viewed as a substitute for full funding of the Comprehensive Children's Mental Health Act.

- The definition of target population has critical implications for further development of a system. For example, if the target population is defined too narrowly, the potential to leverage additional federal reimbursement is restricted and ability to integrate service delivery is hampered.

- The use of currently unmatched local dollars to leverage greater medicaid reimbursement does not interfere with the state takeover of non-federal MA because no new local expenditures are required.

- A legislative proposal should be a key products of the Children's Integrated Fund Task Force.

The Local Integrated Fund: How It Works

A. Why Funds Are Integrated Locally

This is a **local** integrated fund model. Dollars are pooled at the local level.

While some states have successfully integrated dollars at the state level, a local approach is required in Minnesota's county-centered public service environment for several practical reasons:

Local governments own and control the greatest share of the dollars used to pay for children's mental health services. In addition, counties are liable for the single most expensive service: Rule 5 residential treatment.

Most services are controlled at the local level. This is particularly true of earlier intervention and family support types of services that the Integrated System is designed to promote.

Flexibility is enhanced because a Local Collaborative can tailor its integrated fund to the unique needs of the community.

Communities that are ready to begin integrated fund initiatives can begin without having to wait for communities that are not ready. On the flip side, communities that are not ready for such an undertaking are not forced into it.

The model encourages a local-state partnership that encourages wider commitment to the reform effort. While integration must take place locally, the state plays a vital role and, therefore, must be engaged in the process.

B. What Local Dollars Are Committed To An Integrated Fund

Partners in an integrated fund do not give up control of their dollars. They negotiate their contributions in relation to the work they, themselves, wish to accomplish. Partners voluntarily contribute resources to a common cause, with the expectation that their agencies will benefit. The Collaborative will have no power to extract involuntary contributions.

Nor is it likely that an agency or school would place its entire budget for emotionally or behaviorally disturbed children into the integrated fund pool.

In general, a partner would commit to the pool those dollars it would spend for mental health services on a child who is receiving care in more than one system or a child who would benefit by receiving services from other systems. The key question is: "Can this agency alone take care of the mental health needs of this child?" If the answer is "no", then the dollars spent on the child should be considered as a potential integrated fund contribution.

Each partner would retain in its own budget the dollars it needs to serve those children for whom it is the sole service provider. To illustrate: a school is providing some special education service to a child. Beyond this, the child is receiving no counseling by an outside therapist or any other mental health service. Nor is the child involved with juvenile court. Further, the school believes that the service it provides is all the child needs; no one has detected any signs of any unidentified disorder. The school, then, would retain the dollars it needs to provide this child's special education service.

The target population greatly determines what dollars are retained or contributed; these are the children that a Local Collaborative is trying to serve. Each partner agency has a group of children that it is mandated to serve. Some of these might be outside of the target. Therefore, the partner must retain in its own budget, the dollars it needs to serve its mandated clients who are not in the integrated fund target population.

If, for example, the Local Collaborative has targeted early identification, some estimate must be made as to the number of children who could potentially benefit from intervening before those children's problem become crises. Then, contributions for the integrated services to these children might be negotiated from each partner based on an estimate of what each agency might save by earlier intervention in these children's lives.

If, on the other hand, the Local Collaborative wants to focus on returning children from residential treatment, contributions can be based on what it costs each system to have a child in placement.

In many instances, population definitions will not provide sufficient guidance for determining integrated fund contributions. Negotiations among integrated fund partners is the only solution. Boundary mismatches, for example, present special problems. School district boundaries frequently cross county lines. Assuming the district wants to be a partner to the integrated fund, how does it respond? Not all of its students live within the county that is trying to initiate an integrated fund. Should the district count the students who reside in the collaborating county and make integrated services available only to them? Or should it negotiate to include students within its entire district boundary?

In the first phase of an initiative, the target population is likely to be narrower than the full-implementation standard defined by the Task Force. Clearly, a community's goals will evolve over time. Contributions will change accordingly.

C. Collective Assumption Of Partners' Funding Obligations

Perhaps the single greatest obstacle to voluntary integration of resources from multiple systems into a local pool is the legal obligation agencies face as payer-of-obligation for certain kinds of services.

Counties, for example, are required by state law to pay for residential treatment (Rule 5) for children. Frequently juvenile court judges order social services departments to pay for such treatment without regard to budgets and without consulting social services administrators.

Schools face federal obligations to provide special education and related services to children whose needs are documented in their Individual Education Plans (IEPs). This obligation functions as a major deterrent to early identification of emotional disorders in the school setting.

In a more general sense, agencies and governing bodies have a natural reluctance to surrender control of their precious resources, even where interagency trust is not a hurdle.

The Task Force recognizes the need to create mutual and enforceable protections for each of the partners in a Local Collaborative. Agencies will find it difficult to commit resources to an interagency pool unless they can be assured that their own obligations will be met -- that they are not leaving themselves vulnerable.

Local Collaboratives will probably wish to address this issue on two levels.

On the routine level, partners will negotiate what work they expect the Collaborative to do and agree to financial commitments commensurate with getting that work done. Children will presumably be accepted into the integrated system as collective clients of the Collaborative. Relative contributions to the integrated fund will depend upon which agency is getting what work done by the Collaborative.

Yet, what about the unexpected obligations? What about the unbudgeted court order or the seriously disturbed child who requires an extraordinarily long stay in residential treatment? What happens if, in the early experimental phase, a Collaborative miss-estimates its expenditure projections?

On the extraordinary level, the Task Force proposes that Local Collaboratives formally agree to collectively assume the service funding obligations of their partner agencies to the extent necessary to create an atmosphere of confidence for funding integration. The partners would negotiate a risk-sharing formula: what obligations are assumed, the portion to be assumed, and the process used to trigger and transfer that obligation.

Mutual protection of the Collaborative partners is essential to expanding system capacity for earlier identification and intervention. From its earliest discussions, the Task Force has promoted some means to collectively assume responsibility for the treatment of children whose need for early intervention is ignored as responsibility is shifted from one sector to another.

Particularly critical are those children whose disorders could be identified by school staff. Schools have the greatest access to the greatest potential number of disturbed children. Yet, it is well known that schools are reluctant to identify problems for fear of having to pay for treatment.

Indirectly, counties' obligation to pay for

Rule 5 residential treatment could play into a shortage of resources for earlier intervention. Since counties must pay for residential treatment, they may be reluctant to shift dollars into early intervention services provided through the integrated children's mental health system. With a shortage of early intervention resources, more children land in residential treatment.

However, if the other partners were to assume some of the burden for unbudgeted placements, counties might be persuaded to contribute some dollars budgeted for residential treatment to the integrated system. This could create a chain-reaction: providing more dollars for early intervention, which reduces the need for placement, which provides still more dollars for early intervention. Thus, the shift of resources away from the deep end of the service continuum begins.

Partners can draw up agreements that prohibit each of them from abandoning a Collaborative once collective obligations are assumed or agreements that establish a mechanism for apportioning court-ordered services or federally-mandated obligations among partners. In at least one state, partners agreed to help pay for the cost of federal special education mandates for services provided through the integrated fund that were additional to current special education services.

D. General Recommendations On Local Funding Integration

The Task Force studied other states' experience, always with an eye to how it would inform Minnesota. Ideas that seemed to work elsewhere were tested against what Members knew about Minnesota's politics, laws, professional climate, and state-local relationships. After nine months of study and debate, the Task Force arrived at these general recommendations on local funding integration:

- The service system design should drive financing strategy. The goal of integration is to get the most beneficial service to the child at the most advantageous moment, so funding and service delivery must function in concert.
- Changes cannot be driven by any single system. Initial consensus must be sought across local systems in defining the target population to be served by integrated funding.
- The integrated fund approach should use **positive** financial incentives for local participation and cooperation;
- The client population should include both Medical Assistance-eligible and non-MA-eligible children; that is, a funding pool receiving medicaid dollars should also be designed to serve non-MA-eligible children.
- Local initiatives should be allowed to create governance structures that allow

the current expenditure of unmatched local funds to be counted toward the maximization of federal reimbursement.

- Start up funding for local initiatives is needed to provide technical assistance in restructuring local service delivery systems.

- Resources should be developed for state-level support to local communities who are initiating integrated funds. The state should support local efforts with technical assistance, planning staff, and by providing regulatory flexibility.

- Private insurers and providers should be partners in the integrated system whenever possible and the integrated fund should be used to complement private insurance and other private dollars.

- Sophisticated fiscal administration and management systems are critical in order to permit resource management that is flexible enough to quickly reallocate dollars from one client to another as service needs demand.

- Accountability at both the state and local levels should be built into the system.

- Local communities should pool resources and share risks on a regional basis where necessary to achieve an adequate client base for feasible integration.

- Court-ordered juvenile justice expenditures should be addressed in planning for a local integrated fund.

- Any local dollars can be used to match medicaid expenditures for eligible clients including private insurance and charitable grants.

The Revenue Enhancement Mechanism

A. How Revenue Enhancement Works And Its Potential For New Dollars

Integrated funding creates an opportunity to increase federal reimbursement from Medical Assistance (MA), Title IV-A, and Title IV-E without a commensurate increase in state and local expenditures. Thus, the integrated fund mechanism itself becomes a source of new revenue.

Currently, local communities spend large sums of money on children with emotional and/or behavioral disorders that do not receive a federal match. Many of these are expenditures on services that are not defined as mental health services. Dollars spent in other systems, such as juvenile justice funds spent to provide screening or clinical services to an adolescent residing in a local correctional facility, do not receive MA reimbursement. Nor do local school dollars used to provide special education services to an emotionally disturbed child.

Another category of currently unmatched expenditures that may leverage federal reimbursement are those state funds for mental health services which are not in state MA Plan.

By pooling these unmatched local expenditures, along with traditional mental health dollars, into an integrated children's mental health fund, the entire pool becomes a mental health pool that is then eligible for federal MA reimbursement.

The potential is significant. Medicaid reimburses Minnesota 54.43 percent of every MA dollar spent. Projections by the Department of Human Services suggest that Minnesota could hope to earn $10 million to $20 million dollars per year in new federal dollars for children's mental health services with statewide implementation of the integrated fund strategy.

Guesses based on Ohio's experience with integrated funding hints at an even greater return. That state increased it Federal Financial Participation (FFP) by more than 1,000 percent over a six year period using the type of methodologies studied by the Task Force.[2] Its per capita rate of Medicaid reimbursement is estimated to be three times higher than Minnesota's as a result of integrated funding.[3]

Securing the new federal dollars for children's mental health requires an additional step. Any new Medicaid reimbursement would come back to the state's General Fund unless it is legislatively assigned to a special revenue fund, or some other mechanism, to catch the dollars and return them to the Local Collaboratives for reinvestment into children's services.

MA reimbursement must be earned on MA-eligible clients. However, it is not necessary to know precisely which dollars serve MA-eligible children because reimbursement eligibility can be determined by an allocation formula based on the number of MA-eligible children being served. The new federal dollars earned, however, can be spent on any child. Thus, while it is necessary for a local integrated fund to track which of its clients are MA-eligible, the integrated fund may serve both MA-eligible and non-eligible children.

Implementation of an integrated fund is not without additional administrative costs. Refinancing strategies should reallocate a portion of the enhanced revenues back to administrative expenditures at both the local and state levels.

The revenue enhancement mechanism of an integrated fund serves clients in two ways. First, it provides a new source of dollars which, given the current budget climate, may be the only source of new money for mental health in the near future.

Second, the federal government has allowed greater flexibility for innovative financing schemes than is possible with a traditional Medicaid program.

A report[4] by The Center for the Study of Social Policy suggests testing any refinancing strategy against three criteria:

- It should be possible without the expenditure of additional local or state dollars. Local Collaboratives would identify expenditures already being made by local agencies that can be used as matching funds for new federal reimbursement;
- It should not put the state at any additional risk of audit exceptions or federal financial penalties. "Awareness and adherence to technical requirements must be integrally woven into the refinancing strategy selected";
- The benefits should outweigh the technical and political difficulties involved in developing and implementing an integrated fund.

B. General Recommendations On Revenue Enhancement

- The state should pass legislation that would allow the expenditure of local funds to be counted as match for medical assistance and other federal funding.
- New dollars realized from revenue enhancement efforts should be reinvested into the integrated service system to enhance the state's comprehensive children's mental health system.
- The state should be subject to a maintenance of effort standard to prevent shifting the burden of the non-federal share to counties.
- Revenue enhancement should not be permitted to supplant current resources.

Integrated Funding Strategies

Many states are experimenting with integrated funding. Although no two states have approached the effort in exactly the same way, each approach is built upon a some combination of the same small set of funding strategies. Success, according to national experts, depends upon combining several strategies in mutually reinforcing ways. Many, but by no means all, of the most common strategies focus on federal Medicaid dollars: first, to make their utilization of those dollars more flexible; second, to get more dollars, by increasing reimbursements.

Medicaid/Medical Assistance Strategies

Medicaid refers to the federal program and federal dollars which are used in combination with state dollars to operate Minnesota's Medical Assistance program. ("Medicaid" and "Medical Assistance" are often used interchangeably.) For every Medical Assistance dollar which Minnesota spends on an eligible client, the federal Medicaid program reimburses 54.43 percent.

Medicaid-related strategies for integrated funding are of two broad types: (1) the waiver of those federal Medicaid rules which limit reimbursement and (2) the amendment of state Medicaid plans in order to expand reimbursable services. The Task Force studied both approaches; its findings are outlined below.

Medicaid "waivers" and "exceptions" provide relief from the strict rules that govern what services or administrative expenses the federal government will reimburse through Medicaid funds. The effect is to expand the use of Medicaid dollars to a broader range of services, thereby making Medicaid dollars more flexible in a way that contributes to a strategy developed by a particular state.

The difference between a waiver and an exception is this: a waiver (which waives certain rules) must be applied for by the state and approved by the federal Health Care Financing Agency (HCFA), currently a complex and time-consuming process; whereas, an exception allows a state to deviate from several rule requirements without federal approval. In common parlance, both are generically referred to as "waivers".

Waivers are a response to state governments which have said that strict procedural accountability is inefficient and ultimately costs the taxpayer more money. They are a federal strategy to allow states more flexible use of the Medicaid dollars in order to test new approaches to medical care, including mental health care, that may save money and improve service quality. When a state applies for a waiver or undertakes an exception, it is offering to make a trade with the federal government. In exchange for the more flexible use of its dollars, the federal government demands something in return: usually the state must agree that its total expenditures for the specified population of clients will be less than, or no more than, what the expenditures would be without the waiver.

Understanding waivers is complicated by the language used to define them. A waiver does not, strictly speaking, grant a state new powers; instead it stipulates those rules to which the state will no longer have to adhere. The numbers designating the various waiver types refer to chapters in the federal Social Security Act that describe the waiver.

A **1915(a) exception**, as used to develop integrated funding strategies, allows a state to create a program for Medical Assistance clients in which a state pays a provider on a prepayment basis to provide an agreed-upon set of services to a specified population of people, should anyone in that population need those services. The payment rate is referred to as a "capitated rate" (i.e. per-capita rate) because it is paid on the number of individuals in the population to be covered. A **pre-paid capitated** program works like an insurance program in that payment is made, not for each actual service provided, but to cover the provider's risk of having to serve clients within a certain population.

Chapter 1915(a) of the Social Security Act says that, if a state contracts on a prepayment basis with a comprehensive health service provider whose benefits include services not in the state Medical Assistance plan, the state can be released from having to provide those services statewide (a "statewideness" exception) and may restrict coverage of those additional services to a defined group of clients who are to be covered by the comprehensive provider (a "comparability" exception).

A least one service in addition to those already available in the state MA plan must be provided. In order to receive federal reimbursement, services under the program must be Medicaid-eligible services, but the comprehensive provider may provide other non-eligible services without expectation of reimbursement.

MA-eligible children cannot be forced to receive their mental health services through the pre-paid provider under a 1915(a) exception. Medicaid rules give clients the freedom to choose their health care providers; to restrict a client's "freedom of choice", a state must obtain a waiver called a 1915(b). Once enrolled, however, a client can be locked into the prepaid program for up to two months and the client cannot receive covered services from other providers.

A 1915(b) waiver allows four types of arrangements:

A primary-care-case-management or specialty-physician-services arrangement allows the state to implement an arrangement to restrict the provider from whom a recipient can obtain services as long as access to quality services is not limited. The primary care case management arrangement requires that a case manager be responsible for arranging primary care and rehabilitative services for a client. A specialty physician services arrangement allows states to restrict recipients of specialty services to designated providers.

A **locality-as-central-broker-arrangement** permits a state to allow a county or district to act as a central broker in helping clients to select from among competing health care plans.

A **sharing-costs-with-recipients** arrangement allows a state to share with recipients, through the provision of additional services, the savings resulting from a recipient's use of more cost-effective care. For example, a program may offer additional services as an incentive for clients to participate in case management or some other cost-saving arrangement.

A **freedom-of-choice** arrangement allows a program to restrict clients to using specified providers that comply with certain reimbursement, quality, and utilization standards.

A **1915(c) home and community-based services waiver** allows HCFA to waive statewideness and comparability requirements in order to address the needs of clients who, otherwise, would have needed costly MA-reimbursable institutional care. A 1915(c) program may target a specified population. It also allows a state to determine eligibility using the same criteria that would apply to a child receiving institutional care; that is, not deeming parents income as countable when determining the child's financial eligibility. (This is referred to as a "deeming waiver".) The program must be more cost effective than before the waiver. The waiver is granted for two years without renewal.

The 1915(c) approach, while it has worked well for developmental disabilities, has limited applicability for the mental health population in Minnesota. The vast majority of residential treatment for emotionally disturbed children takes place in Rule 5 facilities that currently are not eligible for Medicaid reimbursement. State rule changes could establish their eligibility, but questions on the appropriateness of committing residential treatment to a medical model -- a part of MA eligibility -- are unsettled in the broad mental health community. A very small number of children with emotional disorders are receiving treatment in two state Regional Treatment Centers, that are MA-eligible.

A 1115(a) demonstration waiver allows the state to undertake demonstration projects to test their viability and cost effectiveness. It permits the waiver of the same body of provisions as the other chapters, plus (1) the requirement for the state MA authority to contract with non-HMOs; (2) the requirement to contract with organizations meeting the required 75 percent Medicare/Medicaid enrollment limitation; plus (3) it allows the state to restrict recipients from disenrolling upon demand.

Minnesota currently uses this authority to provide the prepaid, capitated health care program for AFDC recipients called the "Prepaid Medical Assistance Program (PMAP). It currently operates in Hennepin, Dakota, and Itasca counties; Ramsey County will come into the program this year.

State Medicaid plan amendments are used to expand the list of services that can receive federal Medicaid reimbursement. A plan amendment is a state-level action; by adding a service to the plan, the Legislature is, in theory, agreeing to spend more state dollars to pay for the non-federal share of the service costs. However, in the instance of the Integrated Children's Mental Health Fund, dollars that already are being spent at the local level would make up the non-federal match for the added services.

Some services are mandatory under federal Medicaid law. Others are "options"; that is, they are defined by federal law, but states may, or may not, choose to provide them. The option with the greatest potential for integrated funding strategies in Minnesota is described below:

The rehabilitation services option (or "rehab option") already is included in Minnesota's Medical Assistance plan. The Task Force proposes to expand the list of services provided under the rehabilitation services option for children being served by an integrated children's mental health system.

"Wrap-around services" would be a primary beneficiary of the proposed amendments. The Task Force expects that, within a treatment plan prepared by an MA-certified care planner, a variety of non-traditional services could become eligible for federal reimbursement, including services provided by non-mental-health providers.

Federal administrators define the rehabilitative services option as "*medical or remedial in nature for the maximum reduction of physical* ***or mental disability*** *and restoration of a recipient to his (sic) best possible functional level. While it is not always possible to determine whether a specific service is rehabilitative by scrutinizing the service itself,* ***it is more meaningful to consider the goal of the treatment.***"[5]

The only children's mental health services currently covered under the state's rehabilitative services option are "professional home-based family treatment and day treatment. The Task Force proposes to add -- for areas where integrated children's mental health collaboratives exist -- three services to those eligible for MA reimbursement :

- Family Community Support Services (FCSS)
- Residential Treatment (Rule 5)
- Therapeutic Support for Foster Care.

Approximately $36 million a year[6] is spent on these three services for both MA-eligible and ineligible children. To include them under the state MA plan could yield an additional $9.4 million each year in federal reimbursement on the MA-eligible portion.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Strategies

(now called "Child and Teen Check-Ups" in Minnesota)

Under federal EPSDT laws, a state is required to furnish children and adolescents up to age 21 with all medically necessary diagnostic and treatment services that are federally allowed under section 1905(a) of the Medicaid statute even if the services are not otherwise covered in the state's Medicaid plan. There is no comparability requirement to furnish this service to adults.[7]

Although EPSDT is not a mental health program, states can set screening and treatment standards for emotional disturbance for use by EPSDT screeners.

An EPSDT program can be established in schools to help identify emotional or behavioral disorders early. Identification through this screening, according to some experts, gives wide latitude to pay for necessary treatment with Medical Assistance dollars.

EPSDT appears to be a flexible and potentially lucrative enhancement source for Minnesota, despite the fact that the state already includes the delineated EPSDT services in its MA plan. Somewhat nebulous, the bounds of EPSDT-eligible services are always changing. To illustrate: if a psychiatric assessment, that was triggered by an EPSDT screening, determines that a child needs a service not in the MA plan, that service is, in effect, on the table for discussion. The state may deny its eligibility. The question can land in court and the court decision sets precedent for the future eligibility of that service for MA reimbursement.[8]

Schools, which are among the best situated to find children with early disorders, have no responsibility to pay the non-federal share for treatments indicated by EPSDT screenings, particularly if the program is conducted by the local public health agency with the school merely allowing the use of its space.

Doctors can order services via EPSDT that are not otherwise available through the state MA plan. In addition, the program can be used to trigger services to children who are MA-eligible but who have not applied for Medical Assistance, perhaps due to the stigma sometimes attached to public assistance. While EPSDT is a flexible funding source, there is nothing in its structure to ensure management of care.

Title IV-A Emergency Assistance (EA) Strategy

Success with this strategy in other states suggests that federal Emergency Assistance holds much potential for Minnesota -- perhaps second only to Medical Assistance -- for increasing federal revenues. It reimburses 50 percent of eligible state expenditures.

EA is a very flexible funding source that can be used for just about anything that is deemed useful to help a family through an emergency. The concept of "emergency" can be tied to mental health by defining as an emergency those conditions that put a child at risk of being removed from his or her home, according to national consultants.

The built-in flexibility would support the Integrated Children's Mental Health System concept of "wrap-around services", which are those innovative and non-traditional activities that can facilitate traditional services or be substituted appropriately for a more expensive service.

There are limits with EA. It would not apply to children whose situations cannot be defined as an emergency. It can be tapped only once in a twelve-month period. Its use is limited to a six-month duration, but states are starting to push this outward.

Title IV-E Strategy

Title IV-E of the Social Security Act provides entitlement funding for child welfare services and authorizes reimbursement for a broad range of services to vulnerable children. They include: foster care, subsidized adoptions, and the administrative costs associated with managing the program: administrative costs include case management and pre-placement assistance. Title IV-E is for all children who are poor, defined as those who otherwise are eligible for Aid to Families with Dependent Children (AFDC).[9]

Other states have moved to restructure Title IV-E reimbursements, much in the same way that Medicaid is used. While the Task Force has not investigated this strategy, Title IV-E reimbursement is a focal point of the Family Preservation Investment Project (at the Department of Human Services). The federal Family Preservation Act directs additional earnings from Title IV-E back to counties, a portion of which is eligible for mental health services.

The Problem of ERISA

The 1974 Employee Retirement Income Security Act (ERISA) is not an integrated funding strategy, but a barrier that Minnesota will have to face in trying to provide mental health services to children.

ERISA exempts any self-insured company from state regulation. As a result, no state law enacted to require insurers to provide mental health services to workers' children can be applied to employer plans that are self-financed. Since 60 percent of Americans insured through their employers are covered by self-insured plans (and the number is growing), ERISA has the potential to frustrate state attempts to reform medical care, including mental health reform. In fact, state medical reform efforts are cited as one factor contributing to the growth of employer self-insured plans.[10]

Employers commonly use self-insurance to restrict coverage, sometimes even restructuring benefits after a beneficiary has developed a need for expensive treatment. Those who are cut out of self-insured plans often end up on the Medicaid roles, thus shifting the insurance costs to taxpayers.

Section Notes

1. See discussion in the earlier companion report, *The Children's Mental Health Integrated Fund: A Preliminary Report*, Minnesota Department of Human Services, May 1992, p. 87.

2. See *Operation Help: Advocates Guide to Medicaid*, National Mental Health Association, Washington, D.C. 1988.

3. This is an unverified estimate based a conversation between a Task Force member and a leader of Ohio's community mental health center association. Even if the projection is not precise, it does suggest a strong incentive to further pursue integrated funding strategies.

4. See *Leveraging Dollars, Leveraging Change: Refinancing and Restructuring Children's Services in Five States*, The Center for the Study of Social Policy, Washington D.C., September 1991, p. 16.

5. Memo from the Director, Medicaid Bureau, Health Care Financing Administration, U.S. Department of Health and Human Services, to Regional Medicaid Administrators, October 1992.

6. Based on DHS Mental Health Division analysis of the first three quarters of CY 1992, Department of Human Services (SEAGR report) data, '92-'93 county plans, and county surveys.

7. See *Using Medicaid to Finance Care Coordination Services for Children and Adolescents with Severe Emotional Disorders*, Harriette B. Fox and Lori B. Wicks, Fox Health Policy Consultants, Washington D.C.; prepared for the Research Foundation for Mental Health, Inc. with funding from the Child and Adolescent Services System Program (CASSP) of the National Institute of Mental Health, July 1991, p. 10

8. This scenario was presented by national revenue enhancement expert Karl Valentine, Institute for Human Services Management, New York, in a meeting with the Children's Integrated Fund Task, February 10, 1993.

9. See *Leveraging Dollars, Leveraging Change: Refinancing and Restructuring Children's Services in Five States*, The Center for the Study of Social Policy, Washington D.C., September 1991, p. 16.

10. See *Toward Equal Access: Financing of Mental Health Services by Third-Party Payers*, State Advisory Council on Mental Health, Subcommittee on Children's Mental Health, 1990, p. 8.

IV.

Managed Care And Mental Health

Managed care[1] is a broad concept. The common theme is a system that links fiscal and clinical management to provide negotiated costs and levels of quality. It takes many forms including designated provider networks, pre-paid capitation, managed fee-for-service, utilization review, health maintenance organizations, case management, and others. Mental health services can be included. Originally focused on cost cutting, the concept has evolved to also mean managing services to provide better care.

Integrated children's mental health can live comfortably in a managed health care environment. The service system design proposed by the Children's Integrated Fund Task Force is, in fact, a managed care model for mental health. In addition, the Task Force recognizes the therapeutic and fiscal advantages of linking mental health to primary health care.

However, the state's current managed health care programs for public clients absolutely prohibit the integration of, and the development of comprehensive care plans for, mental health services. Service coordination and comprehensiveness are so crucial to effective delivery of mental health services that any managed health care system which fails to provide an **integrated** mental health benefit, does not truly provide a mental health benefit.

Integration is important because, without it, a child with a serious emotional disturbance often cannot get appropriate care. Without it, provider systems are fragmented -- then both continuity and coordination of care are jeopardized. A fragmented mental health benefit encourages fiscal inefficiencies such as cost-shifting that wastes public dollars.

How children's mental health services will be incorporated into the state's managed health care system is currently unresolved. A work group to be established by the Department of Human Services will study the issue during 1993.

Minnesota's predominant managed care system, the Prepaid Medical Assistance Program (PMAP), began in 1982. It is the mandatory health care plan for Medical Assistance clients in Hennepin, Dakota, and Itasca counties and, thus, covers 20 percent of the state's MA population. Ramsey county will join the program in 1993 and the legislatively-established Managed Care Task Force recently recommended expansion of the program to MA, GAMC, and MinnesotaCare clients in other metro and near-metro counties by 1995. PMAP prepays several health maintenance organizations (HMOs) a per-capita (or "capitated") rate to provide all health care services needed by the enrolled clients.

There are several concerns with PMAP identified by the Integrated Fund Task Force: First, it severely limits the type of services provided. By law, the only services it can provide are those so-called "medically necessary" services allowed in the state Medical Assistance plan. For mental health, PMAP includes a fragmented list of services that inhibits interagency care planning and service coordination. In particular, the list does not include early intervention-type services.

Second, PMAP forces some children to receive only intermittent mental health care because it serves them only during intervals of their lives when they are "disabled by mental illness." By nature, mental disorders are episodic. They create conditions that meet the clinical definition of "disabling" only part of the time. Yet, it is the services provided prior to or between these disabling crisis episodes that offer the best opportunity to move toward wellness or to maintain established progress. These are the services which PMAP often won't provide.

Third, under current PMAP contracts, the HMO contractors have no responsibility to provide residential treatment for children who need it. This has two effects:

- It creates a strong incentive not to provide early intervention services because, with no financial obligation to pay for expensive residential treatment, there is no financial incentive to provide the early intervention services that can prevent placement.
- Second, it shifts the costs of residential treatment to the public sector because, under PMAP, counties remain liable.

In testimony to the Legislature,[2] national human service management consultant Karl Valentine said in reference to PMAP contractors, "They can't just say, 'We've failed with this kid so, community, take over.' All the costs of all the services must be bound up within a system so they have an incentive to offer services early in order to minimize hospital days they'll have to purchase."

Fourth, PMAP severely restricts a community's ability to draw down additional federal Medicaid dollars. Once a child is in a PMAP, no additional federal financial participation can be earned for services provided outside of the HMO, such as school or juvenile justice activities. In addition, EPSDT is, practically, lost as an option; while the PMAP technically must provide it within its contract, the service is commonly diminished[3] and clients are left to enforce their federal rights.

"A partial conceptualization occurred when this system was put together," Karl Valentine said.[4] "Boundaries were set on state and federal investment that didn't account for the costs of services provided in the court, child welfare, and education. So the costs of those services are not available to draw down federal reimbursement."

There are two basic approaches to overcoming the deficiencies of PMAP for children who need mental health services:

(1) revise MA law and PMAP contracts to require the HMOs to provide integrated mental health services or (2) to remove (or "carve out") the mental health service benefit from managed care contracts and bid it separately on a contract requiring the bidder to be:

(a) capable of coordinating the full array of children's mental health services;
(b) participate as a partner in the Local Collaborative in communities where they exist, and
(c) manage together a broad range of funding sources in order to ensure maximum federal reimbursement.

Option 1 has the advantage of extending the care coordination umbrella to include primary medical care and, potentially, chemical dependency treatment and services for the developmentally disabled. It takes advantage of political momentum that is moving toward single-manager health care as a means of reform. Revision of existing contracts, up for renewal in 1994, is feasible if the vendor bidding process is open and truly competitive.

Option 2 allows the integration of mental health services even in a community where no HMO is willing or able to provide a comprehensive array of coordinated mental health services to MA-eligible children. Such a community could be forced to choose between (a) a full continuum of coordinated mental health services which are managed separately from primary care and (b) managing physical health together with an incomplete catalog of mental health services that, thereby, prohibits coordinated care planning. Given this unpalatable dilemma, it is crucial to elect that mental health services be carved out of the managed care package to permit integration with other funding streams.

A carve-out of mental health services recognizes the need to gather mental health resources together, as a first step, so that providers and insurers cannot offer children fragmented mental health service packages. Without an **integrated** mental health benefit, **no** effective mental health service can be provided. To illustrate: If the activities of an orthopedic surgeon were split from those of the anesthetist, the unified service of surgery could not be performed. As top priority, a care manager would first ensure that these activities were linked so that surgery could take place. Thereafter, the care manager would pursue other important links like that to a physical therapist. Fragmenting mental health services is like splitting the surgeon from the anesthetist; an effective service cannot be performed. "Unless the within-system services are integrated, any effort to integrate cross-system services is unlikely to be effective," one national study said.[5]

Carving the children's mental health benefit out of the PMAP plans does not mean a return to the fee-for-service system. The Integrated Children's Mental Health System would manage mental health care; it would simply manage it separately from PMAP in order to facilitate the coordination of services. Current PMAP contractors, which possess a great deal of valuable data and expertise on the management of care, should be encouraged to bid.

The Task Force does not seek separate and parallel integrated systems for mental health, primary care, developmental disabilities, and chemical dependency. In the long term, total care integration is preferable. In the interim, mental health service integration is necessary in order to provide an effective benefit to children or adults with disorders.

The Task Force believes that those who are seeking to manage the mental health benefit risk should look favorably toward the proposed integrated service system design. Through its emphasis on early identification and intervention, the integrated system is focused on stopping the escalation of an emotional or behavioral disorder before it becomes an expensive crisis.

The Task Force makes the following recommendations to the Legislature regarding managed care programs.

1. Where PMAP contracts cannot be revised to provide integrated children's mental health services, the mental health benefit should be separated from the total managed care package and managed as a distinct contract, much like dental services. A public or private vendor could bid on the mental health and/or the physical health benefit packages.

2. It is critical that the mental health managed care system be designed for early access and early identification. Carving out benefits only for SED or disabled children creates a disincentive to early intervention because the managed care entity does not bear the responsibility for the most expensive services that early intervention tries to prevent, nor responsibility for continuous treatment of episodic problems.

3. Managed care for mental health services should be implemented in accordance with the Comprehensive Children's Mental Health Act to ensure statutorily-mandated local planning, service modes, and coordination of those services across systems.

4. The state's Medical Assistance managed care system must not impede the creation of a children's mental health integrated fund and managed mental health care system. Laws of Minnesota 1991 Ch. 292, Art. 6, Sec. 57, Subd. 1 mandates examination of combining "all possible county, state, and federal sources of funds for children's mental health with a view to designing an integrated children's mental health fund, improving methods of coordinating and maximizing all funding sources, and increasing federal funding."

5. Counties must have a mandatory role in the development and implementation of local mental health managed care programs, whether or not counties choose to be the operator of a managed care organization, in order to insure conformance with Comprehensive Children's Mental Health Act requirements.

6. Mental health managed care must ensure the coordination of mental health services and the integration of services with education, health care, juvenile probation, and social services

by means of local interagency agreements and case management, and leveraged or pooled funding from each system.

7. In order to leverage additional Federal resources for Minnesota, mental health managed care must be designed to permit the local integration of funding streams from multiple government agencies, from state and local sources, and from public and private entities.

8. A broadened standard of "medical necessity" must be addressed in local managed care models to ensure that early intervention and other relevant services can be incorporated into managed care to serve a broader population. Integrated funding will be facilitated by a broadened standard for medical necessity that includes both clinical and rehabilitation services.

9. A mechanism to coordinate physical health and mental health systems must be developed. Plus, a link must be developed between children's and adult services to ensure continuity of care and transition services. In general, the PMAP model can be compatible with integrated funding where contracts can be revised to provide an integrated children's mental health benefit.

10. Capitation rates should be set in consideration of new state plan services and historical limits of access. Further, Medical Assistance has only recently been available as a funding source for some mental health services. Because of the previously limited definition of "medical necessity", the state cannot afford to set a capitation rate based on previous or current experience. Capitation rates for mental health services should be based on a study of client needs and phased in gradually as the state gains experience with the new plan.

11. The state should test a number of mental health managed care models because there is insufficient evidence to recommend any single approach. No evaluation of the PMAP model has been conducted with regard to children and families needing mental health services. The one existing study focuses exclusively on adults. Without such a study of children, it would be premature to adopt PMAP as the model for mental health services delivery in Minnesota.

12. If a capitated rate system is chosen, outreach services must be mandatory to counter any tendency not to identify disorders as a way of saving money.

13. A stop-loss mechanism should be built into a managed care system.

Section Notes

1. Managed care is defined, in the January 1993 Managed Care Task Force Report to the Legislature as, "an organized and coordinated health care delivery system that includes: pre-established provider networks and reimbursement arrangements; administrative and clinical systems for utilization review, quality assurance, provider and client servicing; and comprehensive or targeted management of health services."

2. Testimony of Karl Valentine, Institute for Human Service Management, New York, to the Minnesota Senate Health Care Committee, February, 11, 1993.

3. Karl Valentine, in discussions with the Children's Integrated Fund Task Force legislation committee, February 10, 1993.

4. Karl Valentine, *op. cit.*, legislative testimony.

5. See *Integrating Services Integration: An Overview of Initiatives, Issues, and Possibilities*, Alfred J. Kahn and Sheila B. Kamerman, Cross-National Studies Research Program, Columbia University School of Social Work, September 1992, p. 8.

V.

Initiatives That Complement This Proposal

Remarkably complementary reform proposals are emerging across the public sector as child-serving agencies have come to the painful conclusion that they are being overwhelmed by the needs of children and families in distress. Reforms are being proposed in the program areas of child welfare, education, developmental disabilities, and mental health; they include redesigns in service delivery, financing mechanisms, information systems, and revenue enhancement.

Although each of these initiatives began with different populations or different service systems in mind, they were often studying the same children. They discovered that an abused child or a delinquent adolescent commonly has a mental health problem. They discovered that children carrying multiple diagnoses of chemical dependency, developmental disability, and emotional disturbance are routine. The various initiatives found that children's needs often cross system boundaries. As a result, the sharp lines that separate systems and professional disciplines can obstruct efforts to serve children.

It is impossible for staff who have looked at each others' work to ignore the parallels among these initiatives. Nor is it possible to overlook the obvious conclusion: if these complementary efforts could be linked, it would be possible to envision an overall strategy to coordinate all public services to children. An even larger scope of integration could then be considered.

None who are immersed in an integration initiative, such as these in Minnesota, began by "claiming to represent all services and all systems," according to a Columbia University study. "Rather, they represent service integration from a categorical base and sometimes within one categorical arena. Yet few program planners, given a desire to end the problems arising from fragmentation, have disclaimed larger ambitions."[1]

All integration initiatives discussed here address one or more aspects of the "integration triad":

- **service delivery systems** designed to coordinate services across categorical agencies and to tailor service plans to each client based on individual need rather than availability of traditional services;

- **funding mechanisms** designed to create single-source dollar streams that allow client need to drive the system rather than eligibility criteria that are currently attached to clients, services, and providers;

- **information systems** designed to link client and case data across systems, to manage the added complexity of interagency collaboration, and to provide a means of evaluating program performance and client outcomes.

State-level initiatives that are complementary to the Integrated Children's Mental Health System proposal are described below. There may be others; the initiatives listed are those with which Task Force staff and/or members have established links. The appearance of these initiatives here should not be taken to suggest that its principals support the notion of overall integration. Nor has it been determined that these initiatives are utterly compatible; substantive conflicts might emerge upon thorough analysis. Rather, what is described here are those complementary components upon which a strategy of overall children's services integration could be constructed by policymakers inclined to do so. Thus, each description contains paragraphs that identify the project's unique contributions to overall children's services integration:

- The **Interagency Early Childhood Intervention System** addresses the interrelated health, education and human service needs of children birth to age five who are eligible for special education, including children who have an emotional or behavioral disorder (EBD). Much of the project was funded by a federal grant, Infants and Toddlers Early Intervention Program (Part H of IDEA). Currently, service responsibility is determined locally, with state law encouraging the development of local interagency service delivery agreements. Local "interagency early intervention committees (IEICs) have the authority to recommend the assignment of financial responsibility to particular agencies.

In a proposal to the 1993 Legislature, the state Interagency Coordinating Council (ICC), which oversees the project, calls for additional components to its existing interagency system that could be helpful to other children's systems: (1) local interagency agreements delineating responsibility for specific service provision; (2) an interagency system of procedural safeguards (due process and data privacy); (3) interagency processes for both system and child complaint resolution; (4) processes for resolution of disputes between state agencies and for disputes between local agencies; (5) interagency rulemaking; and (6) a single interagency system for supervision and monitoring.

Contributions to children's integration: The project has at least four unique aspects from the perspective of overall children's service integration. First, its service delivery design is strong, regarding interagency coordination; the Children's Integrated Fund Task Force borrowed several of its concepts. Second, the initiative has made great strides in defining procedural safeguards and conflict resolution processes; both would be compatible with our proposed integrated children's mental health system. Third, it involves parents in the development of a child's "interagency family service plan" (IFSP). Fourth, it is an on-going and proven approach that has enhanced service integration through the effective use of existing child-serving programs; it builds on individual agency strengths, rather than creating new organizations or service locations.

In its 1993 report to the Legislature, the ICC recommends improved programmatic and fiscal information systems across agencies because of the crucial role of information in the continued expansion of cross-agency activities. The report identifies the breadth of current funding required and includes findings on short and long term costs of full implementation of its infants and toddlers system. The report does not address specific changes in the design of current funding structures.

- **The Family Preservation Investment Project (FPIP)** focuses on enhancing federal Medical Assistance and Title IV-E reimbursement for family preservation services and case management. It would serve child welfare and children's mental health clients. The revenue enhancement strategy shows some similarities to that proposed by the Integrated Children's Fund Task Force, particularly in counting current local expenditures as part of the state match to draw additional federal Medicaid reimbursement.

  FPIP and Integrated Fund Task Force staffs have been working in close communication and the two initiative are viewed as complementary. It is mutually agreed that there is no "one right way" to approach federal revenue enhancement and that the state can benefit from more than one approach.

  While our Task Force has placed somewhat more emphasis on early intervention, their emphasis on crisis intervention is compatible with our attempts to prevent out-of-home placements both as a more appropriate treatment approach and as a cost-saving measure.

  The project team has developed a legislative proposal for the '94-'95 session.

  Contribution to children's integration: This project team is far ahead of complementary initiatives with respect to the federal revenue enhancement aspects of funding. Both technical development and political consensus building are in advanced stages. Revenue enhancement is a crucial piece of any children's funding strategy because federal Medicaid is expected to be the primary source of new dollars into Minnesota's child-serving agencies in the near future. The project has not proposed any strategy for the integration of the newly enhanced funds. While the project has not proposed a redesigned service delivery system, it points the enhanced resources toward services that would be key to total integration. Additionally, while their emphasis is on child welfare and protection services, the approach would feature interagency coordination; case managers, in their proposal as in ours, would coordinate services across categorical systems.

- **IMPACT (Integrated Management and Planning Act)** would serve children and adults with developmental disabilities. Like the children's mental health initiative, this legislative proposal calls for a comprehensive system redesign that would include: (a) integrated funding, (b) integrated locally-controlled management entities, (c) decategorized and flexible service menus, (d) cross-system information sharing, (e) program evaluation based on client outcomes and performance standards rather than process standards, and (f) service provision determined by client need with greater client control. The state would negotiate and manage contracts with a local management entity and pay for services using either a capitated rate or global budgeting approach. The management entity -- a county, a consortium of counties, or a private agency -- would share financial risk with the state and stand to earn a profit from efficient management.

  Contribution to children's integration: The IMPACT proposal would amplify the authority of the family beyond what the other initiatives have proposed. It would pay the client's family, friends, and neighbors with vouchers or cash grants to provide support services, putting this natural support system in direct competition with vendors. Licensing rules would be changed to allow service provision by an unlicensed provider in such circumstances.

  The state would retain more control here than is proposed by the children's mental health initiative; the Department of Human Services would negotiate contracts with the local management entities and remain as contract manager. However, all formal state authority would lie within the contract so the contract manager role would supplant the state's role as regulator. In communities where the management contract was held by a private agency rather than the county, the county would be altogether out of the business of developmental disabilities, though it would retain its other social services obligations.

- **Managed Health Care** is a system of health care that is organized to provide a client with all of his/her health care needs in a single coordinated package. In Minnesota, the predominant public managed care program is the Prepaid Medical Assistance Program (PMAP), the purpose of which is to control medical assistance costs and manage care for Aid to Families with Dependent Children (AFDC) clients. It is a capitated HMO model. In counties without adequate HMO availability, the state's managed care strategy will take the form of "managed fee-for-service" that will use the traditional system of paying independent practitioners for each provided service; however various managed care strategies will be designed and operated. Integrated Service Networks, also similar to the Integrated Children's Mental Health System proposal, coordinate health care and social service delivery.

  The Integrated Children's Mental Health System proposal is a managed care system for children's mental health services, using similar fiscal management and coordinated care strategies for mental health as Managed Care uses for primary medical care. The Managed Care Task Force, established by the Department of Human Services to recommend expansion of the system, has recommended a pilot of the children's integrated mental health system "to test a managed care model that would provide integrated care management with integrated funding." Members of the Integrated Children's Fund Task Force and DHS Mental Health Division staff were members of the managed care focus group that studied mental health.

Contribution to children's integration:
PMAP has seven years of experience managing physical health care for public assistance clients. Administrative staff are technically proficient in state medical assistance and federal medicaid mechanisms and have established working relations with the federal Health Care Finance Administration (HCFA) regional office that oversees medicaid. The HMO model establishes both functional and administrative integration of primary care, chemical dependency, and mental health services. HMO contractors in the PMAP system vary in their approach to integration: from all-encompassing providers with its practitioners and support services on staff, to HMOs that integrate via a network of independent clinicians.

Although PMAP integrates care across systems, it has never provided a comprehensive array of mental health services for children or adults. This has rendered a highly inadequate mental health benefit. PMAP offers the potential for a more efficient management of health care services. However, if its service array is not expanded, PMAP poses a danger, in the counties where it operates, to mental health service coordination and to the flexible use of medicaid dollars; it could, in its present form, serve as a block to increased federal reimbursement for mental health services. [*See discussion in Section IV. of this report.*]

- **The Social Services Information System (SSIS)** would be compatible with the broad movement toward integration of service delivery systems. It would support the day-to-day efforts of line county social workers and feed client-specific data into a statewide database as a by-product. It would permit program performance evaluations and analysis of client outcomes. With the creation of a common client identifier (called a statewide master index), SSIS could link client social service data with income maintenance and medical assistance data by linking the statewide income maintenance system (MAXIS) and the medical assistance payment system (MMIS) that will incorporate MinnesotaCare data. The system is being designed so that interface could be established with community health, corrections, employment and training, foster and day care licensing, and community mental health centers. County-developed modules (called SSIMS) have been proposed that would link with and facilitate workers use of the system. These modules are being developed on a program-by-program basis, the first priority being family and children's services. A legislative proposal for SSIS has been included in the Department of Human Services budget request. Implementation is projected to begin at the end of 1996.

Contribution to children's integration:
Information integration is the oft-ignored corner of the integration triad, with most of the attention focusing on service delivery and funding. However, an integrated children's system requires cross-agency data access, management, and reporting. While the Social Services Information System is designed to report only about social services clients to the Department of Human Services, the SSIS information structure could be applied across the broader range of clients being served by the children's integrated mental health system to act as the necessary client and fiscal reporting mechanism. However, there is no system currently proposed that could report back to all of the various state departments on the number of their clients, served, the number of their dollars spent, or the types of services provided.

- **The Consolidated Chemical Dependency Treatment Fund**, operating since 1987, is Minnesota's pioneer integrated fund. It combines all federal, state, and local dollars for chemical dependency treatment into a single pool. The program resulted in substantial per-client cost savings. Because it had the concurrent result of drawing more clients into the system, new expenditures have exceeded savings and overall costs have grown.

  Contribution to children's integration:
  The CD Fund has a proven concept of integration and a five-year track record. It also has a solid history of political consensus building and legislative success.

  The CD Fund, however, functions with a narrower scope than that envisioned for the Integrated Children's Mental Health System. It operates within the specific service area of chemical dependency and consolidates funding sources within the administrative jurisdiction of a single state agency: the Department of Human Services.

- **The Pew Charitable Trusts grant** will be used to plan "Family Centers" that would make a broad range of family supports universally available to families of all income levels who have children from birth to 6 years old. Emphasis would be placed on collaboration at the local level, as it is in our Integrated Children's Mental Health proposal.

  Key aspects of the Pew initiative are compatible with the Task Force proposal: (1) emphasis on client strengths rather than weaknesses; (2) emphasis on prevention and early intervention rather than crisis; (3) interagency, rather than categorical, provision of services; (4) blending of formal and informal services (what our proposal calls a "customized package of services"); (5) shifting of power to local communities; (6) linkage of services; (7) cross-system information with outcome focus.

Contribution to children's integration: The Pew initiative, among the complementary projects, is broadest in scope with regard to the population to be served insofar as it is not aimed at a narrow service category such as mental health, child welfare, or developmental disabilities. The Pew Trusts will offer technical assistance to Minnesota to analyze the various funding streams for children's programs and plan for an integrated database to track child and family outcomes.

- **The Action For Children Commission** developed the state's currently operative vision of what children's lives should be like and offered broad recommendations regarding what state government could do to achieve the vision. Its analyses were wide-reaching: the point was not to evaluate specific service programs or systems but to determine what children need. Its recommendations, consequently, were broad and no specific system redesigns were proposed. The Commission is ongoing and its personnel will provide the primary staff functions for the Pew Charitable Trusts grant project.

  Contribution to children's integration: The problem analysis and recommendations published by the Action for Children Commission parallel those of the Integrated Children's Mental Health System initiative. Of six major recommendations, four suggest the need for total children's services coordination and three directly address elements that are a part of our Task Force's design:

  (a) overhauling the state service delivery system; requiring improved coordination of local, state, and federal government programs; and making programs more accountable for results.
  (b) mobilizing communities, schools, and other institutions into an integrated, long-range effort to strengthen families;
  (c) requiring schools to become active partners with parents, community agencies, social and health services, and businesses.

- **The Governor's Children's Cabinet** coordinates public policy on children at the highest level of state government. Made up of the commissioners of Administration, Jobs and Training, Public Safety, Finance, Education, Health, Corrections, and Human Services along with the directors of the Housing Finance Agency and Minnesota Planning. Its mission is to create a flexible system for the comprehensive, unified, and effective administration of programs and services which avoids fragmentation and duplication, and which facilitates cooperation among state agencies as well as regional, local, and private sectors.

Contribution to children's integration:
The Children's Cabinet will coordinate and oversee interagency committees and projects related to children's services. It is charged with the creation of incentives for models of service delivery that encourage integrated and innovative efforts in the delivery of services to children. It must set state priorities that emphasize prevention and early intervention. Beginning with the '94-'95 biennium, the Children's Cabinet worked to set a single, integrated children's budget and a work plan to achieve policy goals. Currently, it is studying a data collection system with a single point of entry and common tracking to better coordinate service delivery. It will create outcome indicators to ensure system accountability.

- **Integrated Children's Mental Health System**

  Contribution to children's integration
  This initiative proposes specific designs for both integrated service delivery and integrated funding and addresses the need for integrated information systems. Its design is more detailed than those of the complementary initiatives and, by encompassing all three aspects of the integration triad, it is broader in scope than those other initiatives that offer specific redesign proposals.

  While the proposal is targeted at children's mental health, its functionally integrated model of service delivery has the broad potential application to other populations and service systems. The local entities performing the integrative functions of multi-agency intake, assessment coordination, multi-agency care planning, unitary case management, and customized service provision could expand the scope of their functions to include all service categories and populations.

  The proposed integrated fund design, again while focusing on dollars spent for mental health services, has broader potential application because it addresses mechanisms for pooling funds from all child-serving systems at local, state, and federal levels including human services, education, juvenile justice, health, jobs and training, and private third-party payers. Additionally, the initiative proposes a revenue enhancement mechanism for leveraging additional federal Medicaid reimbursement.

  The design envisions statewide implementation; it is not a pilot project. All counties would be required to achieve minimum service delivery standards. Analysis included a fiscal resources inventory for children's mental health services. The Task Force has begun discussions with private third-party payers regarding partnership in an integrated system. The Task Force has begun background analysis on governance structures for an integrated system; every initiative which has addressed governance has concluded that governance should be placed largely in the hands of local communities.

It is not surprising that these initiatives should be complementary. A sea change has occurred in the way advocates, providers, and line staff view the systems in which they work. Time after time, the same themes recur when thoughtful professionals talk about improving public services to their clients. Regardless what program area is being discussed, the system they want to see has these characteristics:

(1) One person should have responsibility for a client across all services and agencies.
(2) Services should be coordinated across provider agencies and regulatory departments.
(3) All dollars in the system should be available to all of the system's clients regardless of what service is needed. (It is said that "dollars should follow clients" and that "dollars should be flexible.")
(4) Closely related to the above, providers should be able to draw resources from a single pool without having to mix and match client, service, funding, and provider eligibilities.
(5) In the case of children, parents should have more control over the services which their children receive and should be supported in their efforts to keep their families working. Public resources which help families survive permit families to use their resources to support their own children; in effect, public resources targeted to strengthening families leverage private resources.
(6) Service delivery should be flexible to meet local needs, while meeting statewide performance standards.
(7) All clients should have equal access to state-of-the-art assessment.
(8) In the cases of children, there should be a rational transition into adult services.

Participation in Minnesota efforts to develop cross-agency services for children has been broad-based, including: children's advocates, providers, county and state agency staff, clinicians, insurers, foundations, and national consultants, along with legislators, the governor, and cabinet-level administrators.

It is crucial that none of the initiatives become too self-absorbed. The Columbia study suggests that when integration planners circle the wagons around their own efforts, overall children's services integration can be delayed: "The fact that almost all of the categorical systems conceive of themselves as loci for the integration efforts -- and that all continue their own case management functions, so that multiproblem, multiagency families are being "integrated" by several case managers -- demonstrates the progress yet to be made."[2]

Total children's services integration would face substantial political and technical challenges. Success may depend on choosing what to integrate and what to leave independent. Two basic approaches to integration, as described in Section II, are "functional integration", which creates means for independent agencies and systems to coordinate the efforts each makes on behalf of a individual child, and "administrative integration" which consolidates the key components under a single organizational roof.

Consolidation of all public child-serving agencies and funds into a single monolith would pose large-scale administrative disruption and could produce results that are not altogether better than existing administrative configurations. While all child-serving services would be linked, a children's superagency would not provide for transition into adult services nor link the child's services to those serving the child's parents.

Perhaps, what must be created are not giant new agencies but the mechanisms that will allow existing agencies to work together: integration need not be administrative, but functional. It is not the position of the Children's Integrated Fund Task Force that mental health should necessarily be the loci for integration efforts. The Task Force merely wishes to suggest that its functionally-integrated service delivery model could be used as a means for child-serving agencies to work in concert without a massive restructuring of all agencies into a giant monolith that might ultimately be unproductive.

Nor should total integration of all children's program funds be presumed necessary. Dumping all fiscal resources into a pool that does not distinguish among program areas would likely exacerbate competitive tensions among advocates. Since child-serving systems are continually underfunded, any management policies that, even inadvertently, favored a particular program area over others could potentially leave the unfavored programs without resources. While the integration of all funds serving a particular program area (children's mental health, for example) makes for a better, more comprehensive service, total funding integration may not be essential.

Rather, an argument can be made for continuation of distinct service missions, distinct service technologies, and competing providers. Perhaps what is needed is not a all-encompassing agency but a means to coordinate independent human and fiscal resources. If the recent history of private enterprise, particularly the computer industry, teaches anything to the public sector, it is the importance of agility: the means to quickly reconfigure resources to address fast-changing environments and ever-changing customer needs.

Section Notes:

1. See *Integrating Services Integration: An Overview of Initiatives, Issues, and Possibilities*, Alfred Kahn and Sheila Kamerman, Cross-National Studies Research Program, Columbia University School of Social Work, for the National Center for Children in Poverty, Columbia School of Public Health, September 1992, p.6.

2. *ibid.*, p 8.

Appendix A

Data Update

Local, state, and federal expenditures on children's mental health services are projected to climb 17 percent in 1993 over two years earlier, but children's need for early intervention and community support services continues to be vastly under-financed relative to need.

The newest estimates from the Department of Human Services project SFY '93 expenditures of nearly $74 million, almost $11 million higher than 1991 expenditures of $63.1 million. [See pie graph of *State Fiscal Year 1993 Projected Expenditures* found on page 74.]

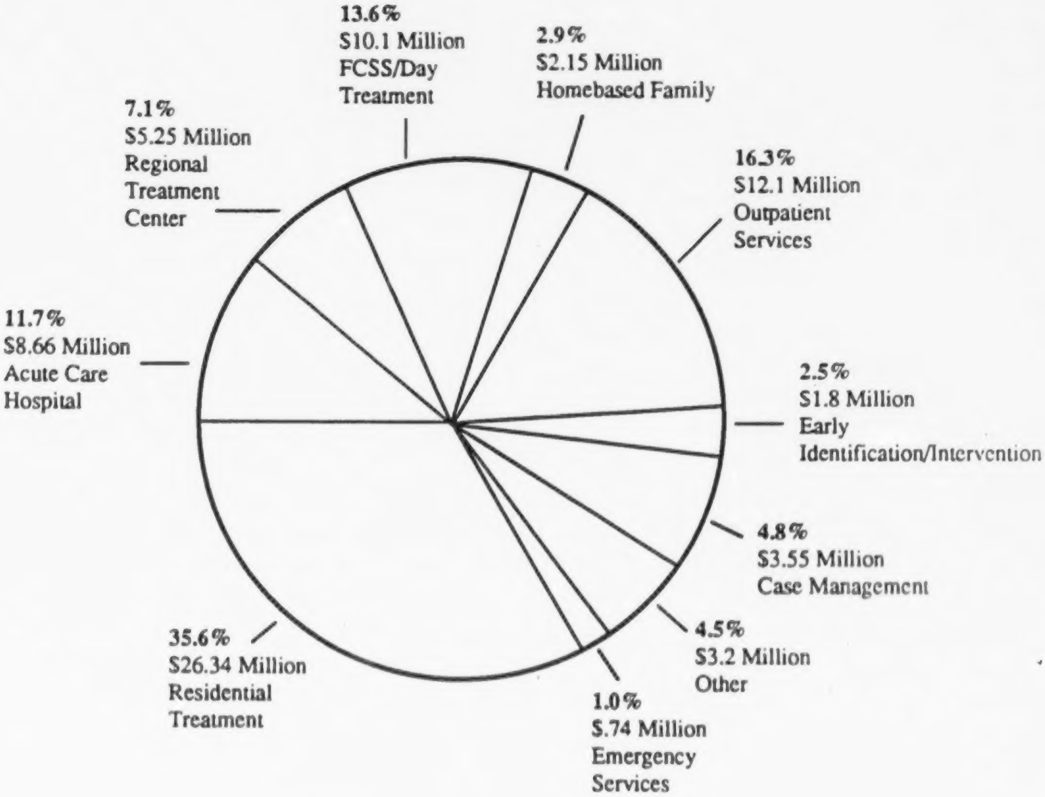
Statewide Service Need, Utilization, and Unmet Need: Children

Service	ED			SED		
	Est. Need	# Served (SFY92)	Est. Unmet Need	Est. Need	# Served (SFY92)	Est. Unmet Need
Family Community Support *	Not Available	400		2,800	200	2,600
Day Treatment		750		2,800	750	2,050
Case Management		750		5,100	750	4,350
Professional Home-Based Trmt		300		2,800	300	2,500
Therapeutic Support/Foster Care		**		1,100	**	1,100
Outpatient Treatment		17,300		20,000	8,000	12,000
Commun Residential Treatment		1,300		150	1,300	(1,150)
Inpatient Treatment		800		1,000	950	50
TOTALS (unduplicated)	100,000	17,000	83,000	23,700	13,700	10,000

* PCSS other than day treatment, professional home-based treatment, therapeutic support.
** Data not available due to recent startup of service.

BEST COPY AVAILABLE

State Fiscal Year 1993 Projected Expenditures for Each Children's Mental Health Service



TOTAL: $73,975,000

In addition to the above, services to children with emotional or behavioral disorders are also funded by the Department of Education, Corrections, Jobs and Training, plus private insurance and private pay.

This table does not include Income Maintenance payments for living expenses.

A slight shift away from out-of-home treatment of children with emotional and behavioral disorders is evident in the projections with the portion devoted to residential treatment, acute hospital care, and regional treatment center care projected to drop 4.5 percent.

Despite the trend toward greater total outlays and relative movement toward community-based services, DHS estimates that only about 2 percent of children who need Family Community Support Services (FCSS) are receiving them. Only 27 percent of children needing day treatment are receiving it and 11 percent of the need for Professional Home-Based Family Treatment is being met. Case management is only somewhat more widely available with 15 percent of children receiving it who need it. [See the *Statewide Service Need* table found on page 73.]

By contrast, while only 150 children are projected to need Rule 5 residential treatment, the lack of alternative services in many communities will force actual usage to 1,300 children or almost nine times more than needed.

The *Unmet Financial Need* table below shows that total funding for the children's mental health system will be $13.65 million short of projected need for 1993. The areas of greatest unmet financial need will be Family Community Support Services, Home-Based Family Treatment, and Therapeutic Support for Foster Care.

Unmet Financial Need: Children's Services

Service	Total Need	Funded SFY 93	Unmet Need
Family Community Support *	$5,500,000	$2,360,000	$3,140,000
Day Treatment	6,500,000	6,300,000	200,000
Case Management	7,000,000	3,500,000	3,500,000
Home-Based Family Treatment	14,000,000	700,000	13,300,000
Therapeutic Support for Foster Care	5,000,000	1,400,000	3,600,000
Early Identification/Intervention	3,300,000	1,800,000	1,500,000
Outpatient Treatment	14,400,000	12,000,000	2,400,000
Commun Residential Treatment	23,600,000	26,300,000	-2,700,000
Inpatient Treatment	11,800,000	13,900,000	-2,100,000
Subtotal (current funding) **	$91,100,000	$68,260,000	$22,840,000
Less already approved increases (primarily MA)		$ 9,190,000	- 9,190,000
Additional Funding Needed			$13,650,000

* Includes all FCSS other than day treatment, home-based treatment, therapeutic support.

** SFY 93 figure is somewhat less than shown in Figure 8, Section II, because not all services are included in this table.

The unmet need tends to be geographically skewed. Despite state law mandating that each county provide a full continuum of children's mental health services, those services are simply unavailable in many communities. [See table below showing *Number and Percent of Counties Providing Each Service*.]

Number and Percent of Counties Providing Each Service in 1992

	Adults		Children	
Service	#	%	#	%
Case Management	87	100%	66	76%
CSP	87	100%		
FCSS			43	61%
Day Treatment	85	98%	34	39%
Community Residential Treatment	84	97%	68	78%
Outpatient Treatment	87	100%	87	100%
Professional Home-Based Treatment			16	18%
Integrated EI/I			30	34%
Therapeutic Support/ Foster Care			6	7%
Community Hospital Inpatient	87	100%	79	91%
RTC Inpatient	87	100%	56	64%

The same table shows a stark contrast with the adult mental health system that has been almost completely implemented throughout the state.

Out-of-home placement continues to play a huge role in the way Minnesota treats its problem children. In 1991, 8,500 children were in some type of placement at some time during the year, according to DHS Substitute and Adoptive Care Report data.

Placement in out-of-state facilities is significant. A snap-shot of Interstate Compact data at the end of December, 1992, showed 177 children placed outside of Minnesota in group homes, residential treatment, or institutional care facilities.

Of those, more than 36 percent were from Ramsey County, which tends to use secure facilities -- unavailable in Minnesota -- for its "juveniles who are both emotionally/behaviorally disturbed and highly delinquent," according to information provided by the Juvenile Division of the Ramsey County Community Corrections Department.

County social services dollars continues to be the largest source of funding for children's mental health services at almost 62 percent. Medical Assistance will fund 30 percent.

Categorical mental health grants still are small, at 6.5 percent of projected expenditures, compared to overall funding. The new MinnesotaCare program plays an even smaller role, at less than 1 percent of total expenditures for children's mental health services. [See pie graph, *Percent of SFY 1993 Funding From Each Source*, found on page 77.]

Federal, state, and local shares of the primary children's mental health services categories are shifting. The state share of case management and family community support services is projected to more than double from 19 percent in 1989 to 40 percent in 1993. [See the bar graph *Children's MH Services -- FY '89 vs. FY '93: federal, state, and county shares*, found on page 78.]

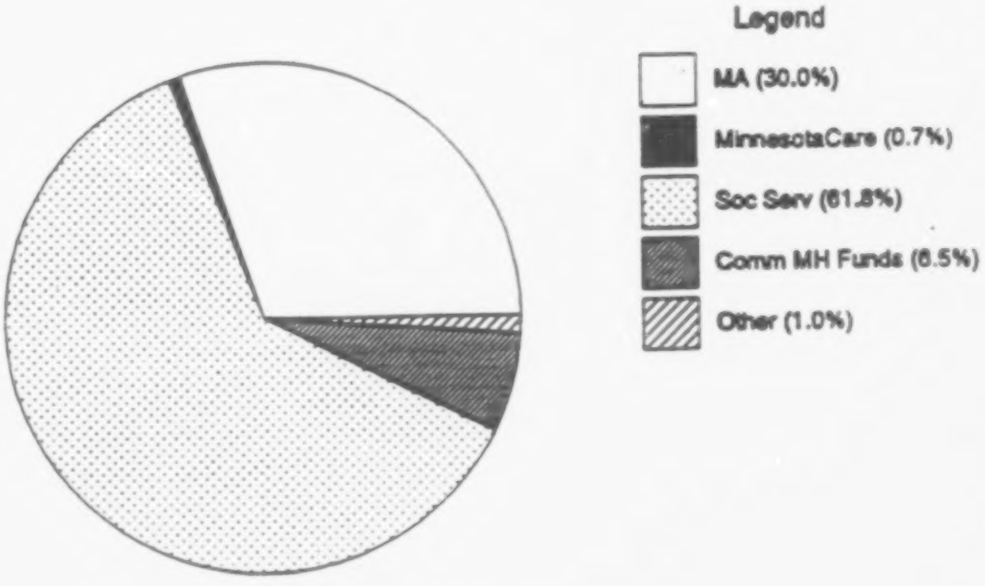
While overall expenditures for Rule 5 residential treatment has climbed in the last four years, both state and county shares have dropped slightly.

Counties, however, will pick up a disproportionately larger share of RTC costs for children with emotional disturbances in 1993.

The chart called *Funding Flows For Children* on page 79 shows how dollars flow through the children's mental health system and the versatility of the primary funding sources. Community Social Services (CSSA) dollars are the most versatile and can be used to pay for any type of service.

Medical Assistance, General Assistance Medical Care, and Minnesota Care (MA/GAMC/Minnesota Care) functions differently than other sources of funding because they flow directly from the state to the providers without going through counties as all other funds do. This difference will add to the technical complexity of creating local integrated funds.

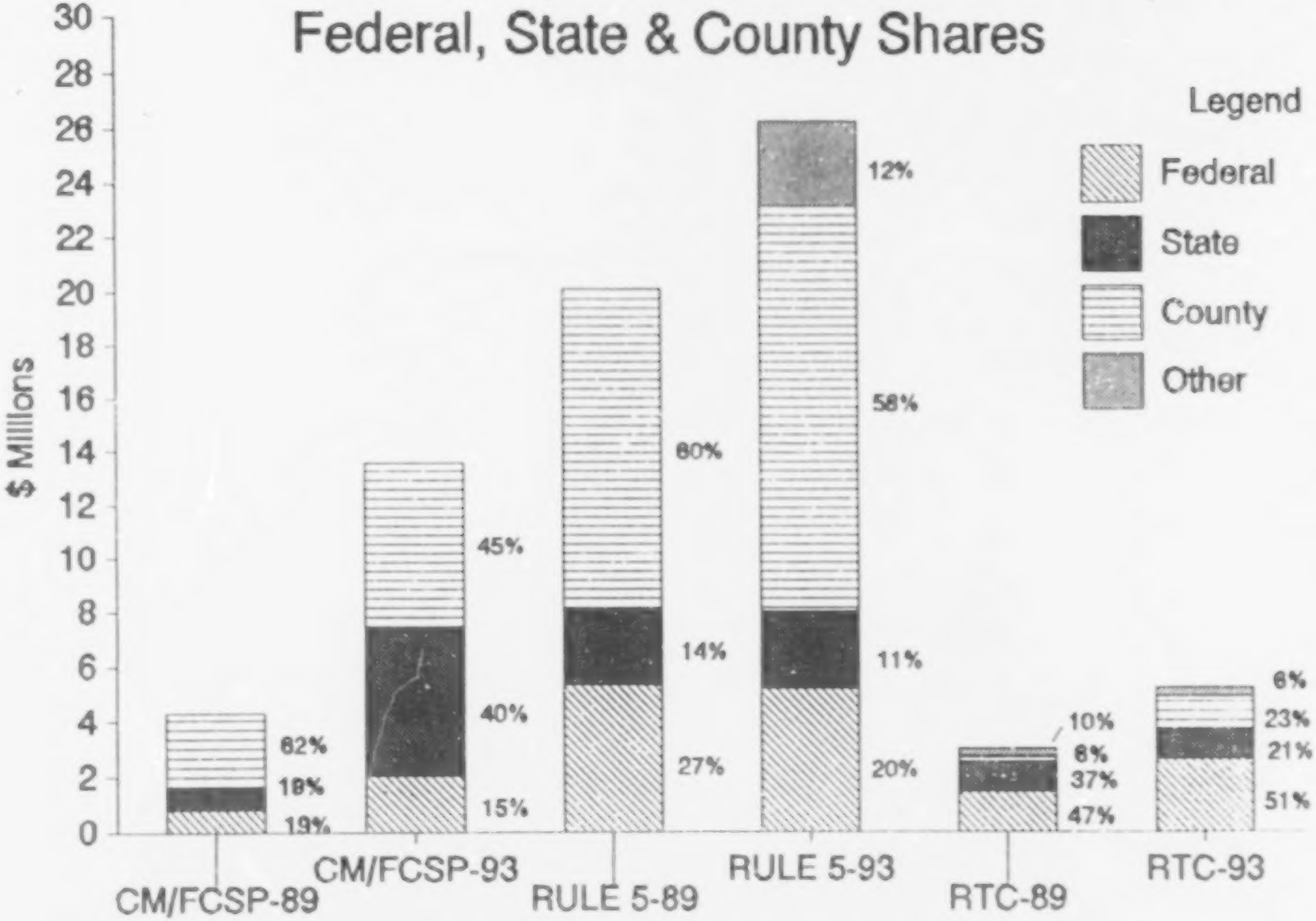
Percent of SFY 1993 Funding From Each Source: Children



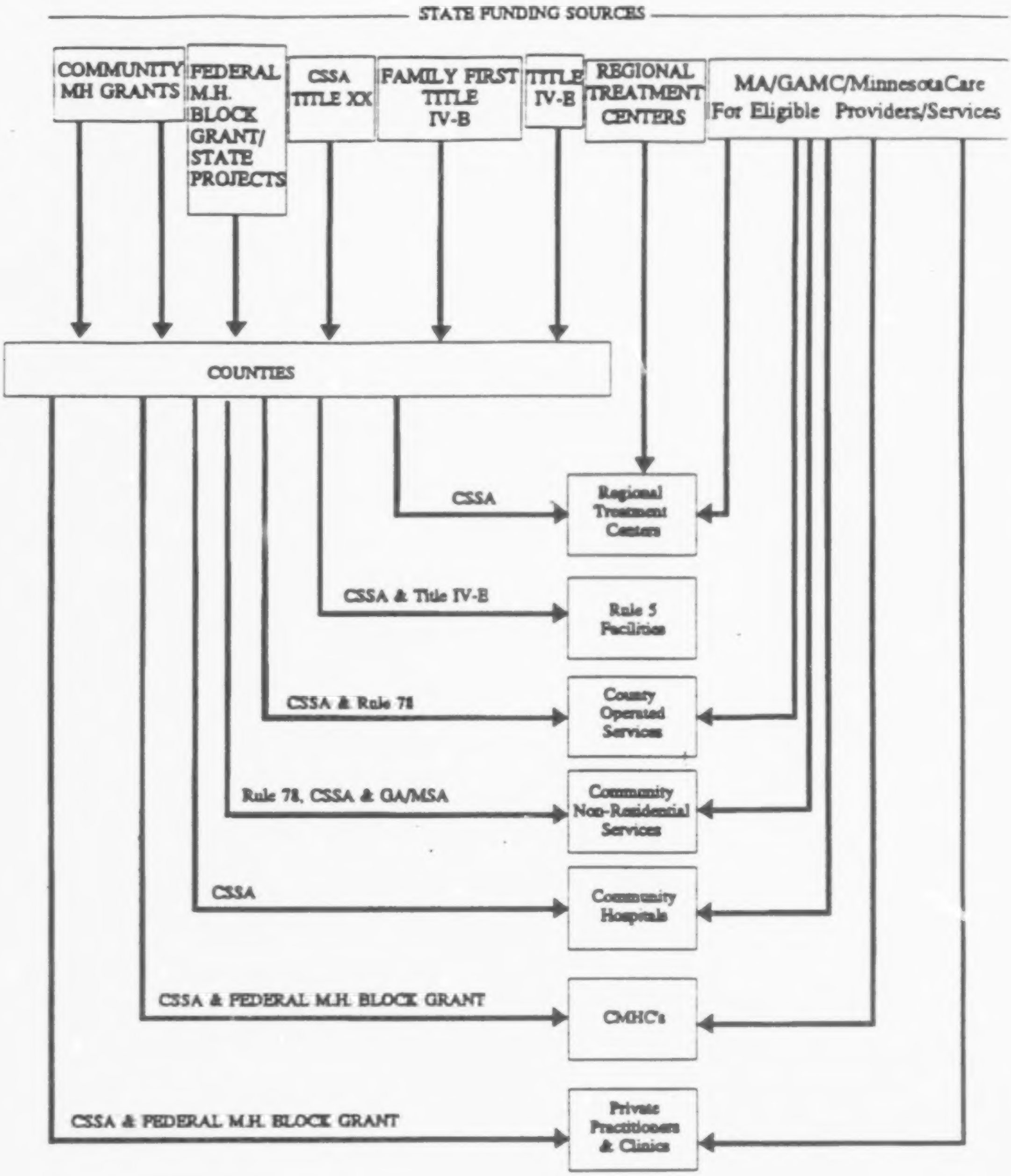
Total Funding: $73,975,000

Children's MH Services- FY 89 vs. FY 93

Federal, State & County Shares



Funding Flows for Children


STATE FUNDING SOURCES
COMMUNITY MH GRANTS
FEDERAL M.H. BLOCK GRANT/ STATE PROJECTS
CSSA TITLE XX
FAMILY FIRST TITLE IV-B
TITLE IV-E
REGIONAL TREATMENT CENTERS
MA/GAMC/MinnesotaCare For Eligible Providers/Services
COUNTIES
CSSA
Regional Treatment Centers
CSSA & Title IV-E
Rule 5 Facilities
CSSA & Rule 78
County Operated Services
Rule 78, CSSA & GA/MSA
Community Non-Residential Services
CSSA
Community Hospitals
CSSA & FEDERAL M.H. BLOCK GRANT
CMHC's
CSSA & FEDERAL M.H. BLOCK GRANT
Private Practitioners & Clinics

BEST COPY AVAILABLE

Appendix B

Target Population Criteria

Formulation of the Target Population for the integrated system and integrated funding required the Task Force to consider many issues. Primary among them were the following:

Early identification and intervention: A goal of the integrated service delivery system is to identify a disorder early and intervene before the disorder advances to a crisis stage. A parent or child should not be forced to wait until a disorder deteriorates before services become accessible.

The most troubled children: The most seriously troubled children already receiving services from multiple systems are likely to benefit greatly from the coordination of their care and services. Coordinated care is likely to reduce the need for out-of-home placement in residential treatment, acute care, and juvenile correctional facilities, thereby allowing treatment to utilize a child's normal support systems and, additionally, allowing services to positively impact dysfunctional environments.

Mental health managed care service carve-out: The target population should be broad enough to permit a Medical Assistance managed care carve out of all children's mental health *services* and to discourage a carve out of a *population* disabled by mental health. A population carve out would divide service delivery into two distinct systems: one serving severe disorders and the other serving less-severe disorders, thereby forcing a child to switch back and forth between service delivery systems as the severity of his or her disorder waxed and waned according to the natural episodic nature of emotional disturbance.

Self or parental referral: The definition should not prohibit assessment and care coordination access to children or parents who have been frustrated in their attempts to access services for their children.

Link to primary care: Linking mental health services to primary care serves several purposes. (1) It permits an integrated approach to a child's total physical and mental health care. (2) It encourages the pediatrician or family physician toward early identification of mental health problems. (3) It eases the political strain of a mental health service carve-out.

Phase-in of the ultimate population target: The definition should describe that population which is the ultimate target of the integrated system. In addition, a "first phase" population should be defined that initially will allow local communities to focus resources on their most critical clients.

Integrated *fund* target as a subset of the integrated *system* target: Those children who will be directly served by integrated fund dollars will be a smaller subset of those children who will benefit from an integrated service system. The system is designed to provide equal access to assessment and service coordination to all emotionally disturbed children. The integrated fund is designed to serve those children whose needs cannot be met by a single system. Access to integrated fund dollars is permitted when any single system serving a child finds itself alone unable to best meet the child's mental health needs.

Consistency with definitions in use among participant systems: To the extent possible, the definition should be compatible with target populations defined in systems participating in the integrated system, particularly the educational system's target for early childhood intervention services.

Encourages integration: The definition of target population by severity of disorder should be avoided. Because any single emotional disorder is episodic and moves through various stages of severity, such an approach would restrict which periods of a disorder could be served and, thus, hamper long-term case planning. Rather the population must be broadly defined to encourage the integration of services and providers appropriate to serve a disorder throughout its full range of stages.

Encourages innovation: Innovation is more likely to result from flexible parameters. So the definition must be flexible enough to encourage innovation, particularly in the first phase of implementation.

Discourage cost shifting: A narrow population definition provides incentives not to identify disorders or to delay treatment until the disorder worsens beyond the obligation of the responsible third-party payer. The cost of treating the client, then, is shifted onto another agency or system.

Appendix C

Integrated Fund Vs. Multiple Checkbook Approach

One of the key policy issues facing the Children's Integrated Fund Task Force was whether to recommend mandatory integration of local children's mental health funds. The choice was between:

(a) allowing local communities a less formal means of collaborative spending, which would have consisted of negotiating the sharing of service costs on a case-by-case basis. We called this the "multiple checkbook approach" because the various partners would bring their separate checkbooks to the case planning table; or

(b) encouraging a fully integrated, single-source pool of funds from which to pay for services to local children.

The Task Force elected for the latter for two primary reasons: First, it would force a more serious commitment to ultimate integration of the service delivery system. Second, the potential for leveraging additional federal Medical Assistance reimbursement is seriously hampered without an integrated fund. In making its analysis of the issue, the Task Force identified the following advantages and disadvantages of each approach (page 84):

Integrated Funding Approach

ADVANTAGES

Allows services to be provided on the basis of need, not eligibility criteria affixed to clients, services, funding sources, and providers.

Easier for direct line staff to access needed services.

More flexible and easier to administer after start-up.

Can lead to more fundamental system change.

Permits management of the mental health system as a whole, especially if the state permits a children's mental health services carve-out within the MA managed care plan.

Leverages additional Medicaid dollars much more effectively than an agency-by-agency approach.

DISADVANTAGES

May need start-up dollars for administrative integration.

Governance is complex.

Start-up work is intense. Plans and trust must be developed.

May require legislative changes.

May require legal action at the local level.

Court-ordered placements could "break the bank" or risk could fall to counties or schools.

Requires incentives, perhaps fiscal.

Doesn't resolve turf issues.

Multiple Checkbook Approach

ADVANTAGES

Easier start-up. Some counties already are familiar with this approach through the Interagency Early Childhood Intervention System where it is working well .

Does not require a mental health carve-out in the medical assistance managed care plan.

It would work in the current fee-for-service environment with no managed care system.

DISADVANTAGES

Service is fragmented by the complexity of categorical funding streams and different eligibility criteria.

Flexible, innovative, and wrap-around services are more difficult to design and deliver.

It retains the distance between agencies and fails to promote mutuality.

Complexity makes administration very difficult.

Accountability is very difficult to track.

Medicaid draw-down is more limited.

It encourages cost shifting.

Appendix D

Children's Integrated Fund Task Force Members

Anne Barry	Minnesota Department of Finance	Task Force
Senator Linda Berglin	Minnesota State Senate	Task Force
Tom Bounds	Alliance for Mentally Ill	Task Force Systems Design Team
William Brakke	Association of Minnesota Counties	Task Force
Ron Brand	Minnesota Association of Community Mental Health Programs	Task Force Funding Team Systems Design Team Legislative Committee
Vickie Brandt	Minnesota Department of Human Services	Task Force Staff Funding Team Systems Design Team Steering Committee Legislative Committee
Bonnie Bray	Minnesota Department of Education	Task Force
Louise Brown	Family & Children's Services	Task Force Funding Team Steering Committee Legislative Committee, chair
Patricia Carlson	Olmsted County Department of Social Services	Task Force

Jeffrey R. Comins	Blue Cross/Blue Shield	Task Force Systems Design Team
William Conley	Mental Health Association	Task Force Funding Team Steering Committee Legislative Committee
Pat Cortese	Northeast Education District	Task Force Systems Design Team
Gary Cox	Minnesota Department of Human Services	Task Force Staff Systems Design Team Funding Team Steering Committee Legislative Committee
Larry Crouse	Minnesota Department of Education	Task Force Legislative Committee
Nancy V. Dagg	Minnesota Department of Human Services	Task Force
Albert V. de Leon	Council of Asian-Pacific Minnesotans	Task Force
Debbie Eng	Minnesota Department of Corrections	Task Force Systems Design Team
Susan Erbaugh	Minneapolis Children's Medical Center	Task Force
Wayne Erickson	Minnesota Department of Education	Task Force
Bonnie Fimon	McLeod County Social Services	Task Force Funding Team
Bob Fischer	Minnesota Department of Education	Task Force
Judge Isabel Gomez	Hennepin county District Court	Task Force Systems Design Team
Rep. Lee Greenfield	Minnesota House of Representatives	Task Force

Elsie Groth	Parent	Task Force Systems Design Team
Jamie Halpern	Robert Wood Johnson Project "Way To Grow"	Task Force Funding Team, co-chair Steering Committee Legislative Committee
Mary Heiserman	Amherst H. Wilder Foundation	Task Force Funding Team Legislative Committee
Sandy Holmstoen	Parent/PACER	Task Force Systems Design Team
Ron Hook	Minnesota Department of Human Services	Task Force
Paul Horn	Region VIII North Welfare	Task Force Systems Design Team
Ann Jaede	Minnesota Planning	Task Force
Marcia D. Jefferys	Minnesota House of Representatives	Task Force
Kathy Kosnoff	Minnesota Mental Health Law Project of the Legal Aid Society	Task Force Systems Team, co-chair Steering Committee Legislative Committee
John Krueger	St. Cloud Children's Home	Task Force
Margaret Langfeld	Association of Minnesota Counties	Task Force Funding Team
Patty Larson	Family and Children's Services	Task Force Systems Design Team Legislative Committee
Julie Lee	Department of Commerce	Task Force

Steve Lepinski	Washburn Child Guidance Center	Task Force Funding Team, co-chair Steering Committee Legislative Committee
Dennis McCoy	Blue Earth County Human Services	Task Force Systems Design Team
Sarah McCumber	Minnesota Nurses Association	Task Force Systems Design Team
Senator Pat McGowan	Minnesota State Senate	Task Force
Christopher McHugh	St. Croix River Special Education District	Task Force Systems Design Team
Thomas F. Micka	Minnesota Society for Child and Adolescent Psychiatry	Task Force Systems Design Team
Sheila Moriarty	Minnesota Department of Human Services	Task Force Funding Team
Carolyn Noehl	Willmar Regional Treatment Center	Task Force Funding Team
Mary Orr	Minnesota State Senate	Task Force
Shirley Patterson	Minnesota Department of Human Services	Task Force
Liz Prebich	Association of Minnesota Counties	Task Force
Richard Quick	Minnesota Department of Corrections	Task Force Legislative Committee
Carol Raabe	Parent	Task Force Systems Team, co-chair
Tom Rice	Minnesota Department of Finance	Task Force Funding Team
Denise Revels Robinson	Minnesota Department of Human Services	Task Force

Susan Roth	Action for Children Commission	Task Force
Jane Mastro Sadovsky	Alliance for Mentally Ill	Task Force
Senator Don Samuelson	Minnesota State Senate	Task Force
David Sanders	Hennepin County Mental Health Center	Task Force Funding Team Legislative Committee
Robert Sawyer	Minnesota Department of Human Services	Task Force
Rep. Gloria Segal	Minnesota House of Representatives	Task Force
Cheryl Smoot	Minnesota Department of Health	Task Force Legislative Committee
Stephen Smothers	Minnesota Department of Human Services	Task Force Staff Systems Design Team Funding Team Steering Committee Legislative Committee
Beth Soderman	Isanti County Corrections	Task Force Systems Design Team
John Staples	Minnesota Administrators of Special Education	Task Force
Joe Steger	Western Human Development Center	Task Force Funding Team
James B. Stoebner	Minnesota Department of Human Services	Task Force
Erin Sullivan Sutton	Minnesota Department of Human Services	Task Force
Ed Swenson	Minnesota Department of Human Services	Task Force
John & Patty Thorwardson	Parents	Task Force Systems Design Team
Cynthia Turnure	Minnesota Department of Human Services	Task Force

Gene Urbain	Minnesota Department of Human Services	Task Force Systems Design Team Funding Team Steering Committee Legislative Committee
Rep. Linda Wejcman	Minnesota House of Representatives	Task Force
Gordon Wrobel	Minnesota Council for Exceptional Children	Task Force Funding Team

Appendix E

Legislative Draft

The Task Force, working with Senate staff, drafted legislation to implement the Integrated Children's Mental Health System.

The bill, S.F. 377, is being authored in the Senate by Sen. Linda Berglin; the House author is Rep. Lee Greenfield.

The Children's Mental Health Integrated Fund bill is being closely coordinated with the Family Preservation Investment Project bill, described in Section V. of this report.

The amended language beginning on the following page was passed out of the Senate Health Care Committee February 24, 1993, and referred to the Education Committee.

treatment of children for whom no appropriate resources are available in Minnesota. Counties are eligible to receive enhanced state funding under this section only if they have established juvenile screening teams under section 260.151, subdivision 3, and if the out-of-state treatment has been approved by the commissioner. By January 1, 1995, the commissioners of human services and corrections shall jointly develop a plan, including a financing strategy, for increasing the in-state availability of treatment within a secure setting. By July 1, 1994, the commissioner of human services shall also:

(1) conduct a study and develop a plan to meet the needs of children with both a developmental disability and severe emotional disturbance; and

(2) study the feasibility of expanding medical assistance coverage to include specialized residential treatment for the children described in this subdivision.

Sec. 11. [245.491] [CITATION; DECLARATION OF PURPOSE.]

Subdivision 1. [CITATION.] Sections 245.491 to 245.496 may be cited as "the children's mental health integrated fund."

Subd. 2. [PURPOSE.] The legislature finds that children with emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and jobs and training. In order to better meet the needs of these children, it is the intent of the legislature to establish an integrated children's mental health service system that:

(1) allows local service decision makers to draw funding from a single local source so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;

(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;

(3) improves the efficiency of use of existing resources;

(4) minimizes or eliminates the incentives for cost and

risk shifting; and

(5) increases the incentives for earlier identification and intervention.

The children's mental health integrated fund established under sections 245.491 to 245.496 must be used to develop and support this integrated mental health service system. In developing this integrated service system, it is not the intent of the legislature to limit any rights available to children and their families through existing federal and state laws.

Sec. 12. [245.492] [DEFINITIONS.]

Subdivision 1. [DEFINITIONS.] The definitions in this section apply to sections 245.491 to 245.496.

Subd. 2. [BASE LEVEL FUNDING.] "Base level funding" means funding received from state, federal, or local sources and expended across the local system of care in fiscal year 1993 for children's mental health services or for special education services for children with emotional or behavioral disturbances. In subsequent years, base level funding may be adjusted to reflect decreases in the numbers of children in the target population.

Subd. 3. [CHILDREN WITH EMOTIONAL OR BEHAVIORAL DISTURBANCES.] "Children with emotional or behavioral disturbances" includes children with emotional disturbances as defined in section 245.4871, subdivision 15, and children with emotional or behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

Subd. 4. [FAMILY.] "Family" has the definition provided in section 245.4871, subdivision 16.

Subd. 5. [FAMILY COMMUNITY SUPPORT SERVICES.] "Family community support services" has the definition provided in section 245.4871, subdivision 17.

Subd. 6. [INITIAL TARGET POPULATION.] "Initial target population" means a population of children that the local children's mental health collaborative agrees to serve in the start-up phase and who meet the criteria for the target population. The initial target population may be less than the

BEST COPY AVAILABLE

target population.

Subd. 7. [INTEGRATED FUND.] "Integrated fund" is a pool of both public and private local, state, and federal resources, consolidated at the local level, to accomplish locally agreed upon service goals for the target population. The fund is used to help the local children's mental health collaborative to serve the mental health needs of children in the target population by allowing the local children's mental health collaboratives to develop and implement an integrated service system.

Subd. 8. [INTEGRATED FUND TASK FORCE.] "The integrated fund task force" means the statewide task force established in Laws 1991, chapter 292, article 6, section 57.

Subd. 9. [INTEGRATED SERVICE SYSTEM.] "Integrated service system" means a coordinated set of procedures established by the local children's mental health collaborative for coordinating services and actions across categorical systems and agencies that results in:

(1) integrated funding;

(2) improved outreach, early identification, and intervention across systems;

(3) strong collaboration between parents and professionals in identifying children in the target population facilitating access to the integrated system, and coordinating care and services for these children;

(4) a coordinated assessment process across systems that determines which children need multiagency care coordination and wraparound services;

(5) multiagency plan of care; and

(6) wraparound services.

Services provided by the integrated service system must meet the requirements set out in sections 245.487 to 245.4887. Children served by the integrated service system must be economically and culturally representative of children in the service delivery area.

Subd. 10. [INTERAGENCY EARLY INTERVENTION COMMITTEE.]

"Interagency early intervention committee" refers to the committee established under section 120.17, subdivision 12.

Subd. 11. [LOCAL CHILDREN'S ADVISORY COUNCIL.] "Local children's advisory council" refers to the council established under section 245.4875, subdivision 5.

Subd. 12. [LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVE.] "Local children's mental health collaborative" or "collaborative" means an entity formed by the agreement of representatives of the local system of care including mental health services, social services, correctional services, education services, health services, and vocational services for the purpose of developing and governing an integrated service system. A local coordinating council, a community transition interagency committee as defined in section 120.17, subdivision 16, or an interagency early intervention committee may serve as a local children's mental health collaborative if its representatives are capable of carrying out the duties of the local children's mental health collaborative set out in sections 245.491 to 245.496. Where a local coordinating council is not the local children's mental health collaborative, the local children's mental health collaborative must work closely with the local coordinating council in designing the integrated service system.

Subd. 13. [LOCAL COORDINATING COUNCIL.] "Local coordinating council" refers to the council established under section 245.4875, subdivision 6.

Subd. 14. [LOCAL SYSTEM OF CARE.] "Local system of care" has the definition provided in section 245.4871, subdivision 24.

Subd. 15. [MENTAL HEALTH SERVICES.] "Mental health services" has the definition provided in section 245.4871, subdivision 28.

Subd. 16. [MULTIAGENCY PLAN OF CARE.] "Multiagency plan of care" means a written plan of intervention and integrated services developed by a multiagency team in conjunction with the child and family based on their unique strengths and needs as determined by a multiagency assessment. The plan must outline measurable client outcomes and specific services needed to

BEST COPY AVAILABLE

attain these outcomes, the agencies responsible for providing the specified services, funding responsibilities, timelines, the judicial or administrative procedures needed to implement the plan of care, the agencies responsible for initiating these procedures and designate one person with lead responsibility for overseeing implementation of the plan.

Subd. 17. [RESPITE CARE.] "Respite care" is planned routine care to support the continued residence of a child with emotional or behavioral disturbance with the child's family or long-term primary caretaker.

Subd. 18. [SERVICE DELIVERY AREA.] "Service delivery area" means the geographic area to be served by the local children's mental health collaborative and must include at a minimum a part of a county and school district or a special education cooperative.

Subd. 19. [START-UP FUNDS.] "Start-up funds" means the funds available to assist a local children's mental health collaborative in planning and implementing the integrated service system for children in the target population, in setting up a local integrated fund, and in developing procedures for enhancing federal financial participation.

Subd. 20. [STATE COORDINATING COUNCIL.] "State coordinating council" means the council established under section 245.4873, subdivision 2.

Subd. 21. [TARGET POPULATION.] "Target population" means children up to age 18 with an emotional or behavioral disturbance or who are at risk of suffering an emotional or behavioral disturbance as evidenced by a behavior or condition that affects the child's ability to function in a primary aspect of daily living including personal relations, living arrangements, work, school, and recreation, and a child who can benefit from:

(1) multiagency service coordination and wraparound services; or

(2) informal coordination of traditional mental health services provided on a temporary basis.

BEST COPY AVAILABLE

Children between the ages of 18 and 21 who meet these criteria may be included in the target population at the option of the local children's mental health collaborative.

Subd. 22. [THERAPEUTIC SUPPORT OF FOSTER CARE.] "Therapeutic support of foster care" has the definition provided in section 245.4871, subdivision 34.

Subd. 23. [WRAPAROUND SERVICES.] "Wraparound services" are alternative, flexible, coordinated, and highly individualized services that are based on a multiagency plan of care. These services are designed to build on the strengths and respond to the needs identified in the child's multiagency assessment and to improve the child's ability to function in the home, school, and community. Wraparound services may include, but are not limited to, residential services, respite services, services that assist the child or family in enrolling in or participating in recreational activities, assistance in purchasing otherwise unavailable items or services important to maintain a specific child in the family, and services that assist the child to participate in more traditional services and programs.

Sec. 13. [245.493] [LOCAL LEVEL COORDINATION.]

Qualify as a collaborative upon agreement

Subdivision 1. [REQUIREMENTS TO QUALIFY AS A LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVE.] In order to qualify as a local children's mental health collaborative and be eligible to receive start-up funds, the representatives of the local system of care, or at a minimum one county, one school district or special education cooperative, and one mental health entity must agree to the following:

(1) to establish a local children's mental health collaborative and develop an integrated service system; and

(2) to commit resources to providing services through the local children's mental health collaborative.

Subd. 2. [GENERAL DUTIES OF THE LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVES.] Each local children's mental health collaborative must:

(1) identify a service delivery area and an initial target population within that service delivery area. The initial

target population must be economically and culturally representative of children in the service delivery area to be served by the local children's mental health collaborative. The size of the initial target population must also be economically viable for the service delivery area;

(2) seek to maximize federal revenues available to serve children in the target population by designating local expenditures for mental health services that can be matched with federal dollars;

(3) in consultation with the local children's advisory council and the local coordinating council, if it is not the local children's mental health collaborative, design, develop, and ensure implementation of an integrated service system and develop interagency agreements necessary to implement the system;

(4) expand membership to include representatives of other services in the local system of care including prepaid health plans under contract with the commissioner of human services to serve the mental health needs of children and families;

(5) create or designate a management structure for fiscal and clinical responsibility and outcome evaluation;

(6) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496; and

(7) explore methods and recommend changes needed at the state level to reduce duplication and promote coordination of services including the use of uniform forms for reporting, billing, and planning of services.

Sec. 14. [245.4931] [INTEGRATED LOCAL SERVICE SYSTEM.]

The integrated service system established by the local children's mental health collaborative must:

(1) include a process for communicating to agencies in the local system of care eligibility criteria for services received through the local children's mental health collaborative and a process for determining eligibility. The process shall place strong emphasis on outreach to families, respecting the family

BEST COPY AVAILABLE

role in identifying children in need, and valuing families as partners;

(2) include measurable outcomes, timelines for evaluating progress, and mechanisms for quality assurance and appeals;

(3) involve the family, and where appropriate the individual child, in developing multiagency service plans to the extent required in sections 120.17, subdivision 3a; 245.4871, subdivision 21; 245.4881, subdivision 4; 253B.03, subdivision 7; 257.071, subdivision 1; and 260.191, subdivision 1e;

(4) meet all standards and provide all mental health services as required in sections 245.487 to 245.4888, and ensure that the services provided are culturally appropriate;

(5) spend funds generated by the local children's mental health collaborative as required in sections 245.491 to 245.496;

(6) encourage public-private partnerships to increase efficiency, reduce redundancy, and promote quality of care; and

(7) ensure that, if the county participant of the local children's mental health collaborative is also a provider of child welfare targeted case management as authorized by the 1993 legislature, then federal reimbursement received by the county for child welfare targeted case management provided to children served by the local children's mental health collaborative must be directed to the integrated fund.

Sec. 15. [245.4932] [REVENUE ENHANCEMENT; AUTHORITY AND RESPONSIBILITIES.]

Subdivision 1. [PROVIDER RESPONSIBILITIES.] The children's mental health collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the collaborative shall designate a lead county or other qualified entity as the fiscal agency for reporting, claiming, and receiving payments;

(2) the collaborative or lead county may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement;

(3) the collaborative must continue the base level of expenditures for services for children with emotional or behavioral disturbances and their families from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under sections 245.491 to 245.496, would have been available for those services. The base year for purposes of this subdivision shall be the accounting period closest to state fiscal year 1993;

(4) the collaborative or lead county must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the contract;

(5) the collaborative shall pay the nonfederal share of the medical assistance costs for services designated by the collaborative;

(6) the lead county or other qualified entity may not use federal funds or local funds designated as matching for other federal funds to provide the nonfederal share of medical assistance.

Subd. 2. [COMMISSIONER'S RESPONSIBILITIES.] (1) Notwithstanding sections 256B.19, subdivision 1, and 256B.0625, the commissioner shall be required to amend the state medical assistance plan to include as covered services eligible for medical assistance reimbursement, those services eligible for reimbursement under federal law or waiver, which a collaborative elects to provide and for which the collaborative elects to pay the nonfederal share of the medical assistance costs.

(2) The commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the requirements of sections 245.493 to 245.496.

(3) The commissioner shall recover from the collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the collaborative's actions or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample.

Subd. 3. [PAYMENTS.] Notwithstanding section 256.025, subdivision 2, payments under sections 245.493 to 245.496 to providers for wraparound service expenditures and expenditures for other services for which the collaborative elects to pay the nonfederal share of medical assistance shall only be made of federal earnings from services provided under sections 245.493 to 245.496.

Subd. 4. [CENTRALIZED DISBURSEMENT OF MEDICAL ASSISTANCE PAYMENTS.] Notwithstanding section 256B.041, and except for family community support services and therapeutic support of foster care, county payments for the cost of wraparound services and other services for which the collaborative elects to pay the nonfederal share, for reimbursement under medical assistance, shall not be made to the state treasurer. For purposes of wraparound services under sections 245.493 to 245.496, the centralized disbursement of payments to providers under section 256B.041 consists only of federal earnings from services provided under sections 245.493 to 245.496.

Sec. 16. [245.494] [STATE LEVEL COORDINATION.]

Subdivision 1. [STATE COORDINATING COUNCIL.] The state coordinating council, in consultation with the integrated fund task force, shall:

(1) assist local children's mental health collaboratives in meeting the requirements of sections 245.491 to 245.496, by seeking consultation and technical assistance from national experts and coordinating presentations and assistance from these experts to local children's mental health collaboratives;

(2) assist local children's mental health collaboratives in identifying an economically viable initial target population;

(3) develop methods to reduce duplication and promote coordinated services including uniform forms for reporting, billing, and planning of services;

(4) by September 1, 1994, develop a model multiagency plan of care that can be used by local children's mental health collaboratives in place of an individual education plan, individual family community support plan, individual family

BEST COPY AVAILABLE

support plan, and an individual treatment plan;

(5) assist in the implementation and operation of local children's mental health collaboratives by facilitating the integration of funds, coordination of services, and measurement of results, and by providing other assistance as needed;

(6) by July 1, 1993, develop a procedure for awarding start-up funds. Development of this procedure shall be exempt from chapter 14;

(7) develop procedures and provide technical assistance to allow local children's mental health collaboratives to integrate resources for children's mental health services with other resources available to serve children in the target population in order to maximize federal participation and improve efficiency of funding;

(8) ensure that local children's mental health collaboratives and the services received through these collaboratives meet the requirements set out in sections 245.491 to 245.496;

(9) identify base level funding from state and federal sources across systems;

(10) explore ways to access additional federal funds and enhance revenues available to address the needs of the target population;

(11) develop a mechanism for identifying the state share of funding for services to children in the target population and for making these funds available on a per capita basis for services provided through the local children's mental health collaborative to children in the target population. Each year beginning January 1, 1994, forecast the growth in the state share and increase funding for local children's mental health collaboratives accordingly;

(12) identify barriers to integrated service systems that arise from data practices and make recommendations including legislative changes needed in the data practices act to address these barriers; and

(13) annually review the expenditures of local children's

mental health collaboratives to ensure that funding for services provided to the target population continues from sources other than the federal funds earned under sections 245.491 to 245.496 and that federal funds earned are spent consistent with sections 245.491 to 245.496.

Subd. 2. [STATE COORDINATING COUNCIL REPORT.] Each year, beginning February 1, 1995, the state coordinating council must submit a report to the legislature on the status of the local children's mental health collaboratives. The report must include the number of local children's mental health collaboratives, the amount and type of resources committed to local children's mental health collaboratives, the additional federal revenue received as a result of local children's mental health collaboratives, the services provided, the number of children served, outcome indicators, the identification of barriers to additional collaboratives and funding integration, and recommendations for further improving service coordination and funding integration.

Subd. 3. [DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.] The commissioner of human services, in consultation with the integrated fund task force, shall:

(1) beginning January 1, 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, separate all medical assistance, general assistance medical care, and MinnesotaCare resources devoted to mental health services for children and their families including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services from the total health capitation from prepaid plans, including plans established under section 256B.69, for the target population as identified in section 245.492, subdivision 21, and develop guidelines for managing these mental health benefits that will require all contractors to:

(i) provide mental health services eligible for medical assistance reimbursement;

(ii) meet performance standards established by the commissioner of human services including providing services consistent with the requirements and standards set out in sections 245.487 to 245.4888 and 245.491 to 245.496;

(iii) provide the commissioner of human services with data consistent with that collected under sections 245.487 to 245.4888; and

(iv) in service delivery areas where there is a local children's mental health collaborative for the target population defined by local children's mental health collaborative:

(A) participate in the local children's mental health collaborative;

(B) commit resources to the integrated fund that are actuarially equivalent to resources received for the target population being served by local children's mental health collaboratives; and

(C) meet the requirements and the performance standards developed for local children's mental health collaboratives;

(2) ensure that any prepaid health plan that is operating within the jurisdiction of a local children's mental health collaborative and that is able to meet all the requirements under section 245.494, subdivision 3, paragraph (1), items (i) to (iv), shall have 60 days from the date of receipt of written notice of the establishment of the collaborative to decide whether it will participate in the local children's mental health collaborative; the prepaid health plan shall notify the collaborative and the commissioner of its decision to participate;

(3) develop a mechanism for integrating medical assistance resources for mental health service with resources for general assistance medical care, MinnesotaCare, and any other state and local resources available for services for children and develop a procedure for making these resources available for use by a local children's mental health collaborative;

(4) gather data needed to manage mental health care including evaluation data and data necessary to establish a

separate capitation rate for children's mental health services if that option is selected;

(5) by January 1, 1994, develop a model contract for providers of mental health managed care that meets the requirements set out in sections 245.491 to 245.496 and 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995, the commissioner of human services shall not enter into or extend any contract for any prepaid plan that would impede the implementation of sections 245.491 to 245.496;

(6) develop revenue enhancement or rebate mechanisms and procedures to certify expenditures made through local children's mental health collaboratives for services including administration and outreach that may be eligible for federal financial participation under medical assistance, including expenses for administration, and other federal programs;

(7) ensure that new contracts and extensions or modifications to existing contracts under section 256B.69 do not impede implementation of sections 245.491 to 245.496;

(8) provide technical assistance to help local children's mental health collaboratives certify local expenditures for federal financial participation, using due diligence in order to meet implementation timelines for sections 245.491 to 245.496 and recommend necessary legislation to enhance federal revenue, provide clinical and management flexibility, and otherwise meet the goals of local children's mental health collaboratives and request necessary state plan amendments to maximize the availability of medical assistance for activities undertaken by the local children's mental health collaborative;

(9) take all steps necessary to secure medical assistance reimbursement under the rehabilitation option for family community support services and therapeutic support of foster care, and for residential treatment and wraparound services when these services are provided through a local children's mental health collaborative;

(10) provide a mechanism to identify separately the reimbursement to a county for child welfare targeted case

BEST COPY AVAILABLE

management provided to children served by the local collaborative for purposes of subsequent transfer by the county to the integrated fund; and

(11) where interested and qualified contractors are available, finalize contracts within 180 days of receipt of written notification of the establishment of a local children's mental health collaborative.

Subd. 4. [RULEMAKING.] The commissioners of human services, health, and corrections, and the state board of education shall adopt or amend rules as necessary to implement sections 245.491 to 245.496.

Subd. 5. [RULE MODIFICATION.] By January 15, 1994, the commissioner shall report to the legislature the extent to which claims for federal reimbursement for case management as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management are consistent with the number of children eligible to receive this service. The report shall also identify how the commissioner intends to increase the numbers of eligible children receiving this service, including recommendations for modifying rules or statutes to improve access to this service and to reduce barriers to its provision.

In developing these recommendations, the commissioner shall:

(1) review experience and consider alternatives to the reporting and claiming requirements, such as the rate of reimbursement, the claiming unit of time, and documenting and reporting procedures set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(2) consider experience gained from implementation of child welfare targeted case management;

(3) determine how to adjust the reimbursement rate to reflect reductions in caseload size;

(4) determine how to ensure that provision of targeted child welfare case management does not preclude an eligible child's right, or limit access, to case management services for

children with severe emotional disturbance as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(5) determine how to include cost and time data collection for contracted providers for rate setting, claims, and reimbursement purposes;

(6) evaluate the need for cost control measures where there is no county share; and

(7) determine how multiagency teams may share the reimbursement.

The commissioner shall conduct a study of the cost of county staff providing case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management. If the average cost of providing case management services to children with severe emotional disturbance is determined by the commissioner to be greater than the average cost of providing child welfare targeted case management, the commissioner shall ensure that a higher reimbursement rate is provided for case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, to children with severe emotional disturbance. The total medical assistance funds expended for this service in the biennium ending in state fiscal year 1995 shall not exceed the amount projected in the state Medicaid forecast for case management for children with serious emotional disturbances.

Sec. 17. [245.495] [ADDITIONAL FEDERAL REVENUES.]

(a) Each local children's mental health collaborative shall report expenditures eligible for federal reimbursement in a manner prescribed by the commissioner of human services under section 256.01, subdivision 2, clause (17). The commissioner of human services shall pay all funds earned by each local children's mental health collaborative to the collaborative. Each local children's mental health collaborative must use these funds to expand the initial target population or to develop or provide mental health services through the local integrated service system to children in the target population. Funds may

BEST COPY AVAILABLE

not be used to supplant funding for services to children in the target population.

For purposes of this section, "mental health services" are community-based, nonresidential services, which may include respite care, that are identified in the child's multiagency plan of care.

(b) The commissioner may set aside a portion of the federal funds earned under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The set-aside must not exceed five percent of the federal reimbursement earned by collaboratives and repayment is limited to:

(1) the costs of developing and implementing sections 245.491 to 245.496, including the costs of technical assistance from the departments of human services, education, health, and corrections to implement the children's mental health integrated fund;

(2) programming the information systems; and

(3) any lost federal revenue for the central office claim directly caused by the implementation of these sections.

(c) Any unexpended funds from the set-aside described in paragraph (b) shall be distributed to counties according to section 245.496, subdivision 2.

Sec. 18. [245.496] [IMPLEMENTATION.]

Subdivision 1. [APPLICATIONS FOR START-UP FUNDS FOR LOCAL CHILDREN'S MENTAL HEALTH COLLABORATIVES.] By July 1, 1993, the commissioner of human services shall publish the procedures for awarding start-up funds. Applications for local children's mental health collaboratives shall be obtained through the commissioner of human services and submitted to the state coordinating council. The application must state the amount of start-up funds requested by the local children's mental health collaborative and how the local children's mental health collaborative intends on using these funds.

Subd. 2. [DISTRIBUTION OF START-UP FUNDS.] By October 1, 1993, the state coordinating council must ensure distribution of start-up funds to local children's mental health collaboratives that meet the requirements established in section 245.493 and whose applications have been approved by the council. The remaining appropriation for start-up funds shall be distributed by February 1, 1994. If the number of applications received exceed the number of local children's mental health collaboratives that can be funded, the funds must be geographically distributed across the state and balanced between the seven county metro area and the rest of the state. Preference must be given to collaboratives that include the juvenile court and correctional systems, multiple school districts, or other multiple government entities from the local system of care. In rural areas, preference must also be given to local children's mental health collaboratives that include multiple counties.

Subd. 3. [SUBMISSION AND APPROVAL OF LOCAL COLLABORATIVE PROPOSALS FOR INTEGRATED SYSTEMS.] By December 31, 1994, a local children's mental health collaborative that received start-up funds must submit to the state coordinating council its proposal for creating and funding an integrated service system for children in the target population. Within 60 days of receiving the local collaborative proposal the state coordinating council must review the proposal and notify the local children's mental health collaborative as to whether or not the proposal has been approved. If the proposal is not approved, the state coordinating council must indicate changes needed to receive approval.

Sec. 19. Minnesota Statutes 1992, section 245.652, subdivision 1, is amended to read:

Subdivision 1. [PURPOSE.] The regional treatment centers shall provide services designed to end a person's reliance on chemical use or a person's chemical abuse and increase effective and chemical-free functioning. Clinically effective programs must be provided in accordance with section 246.64. Services may be offered on the regional center campus or at sites elsewhere in the catchment area served by the regional treatment

BEST COPY AVAILABLE

Appendix F

Glossary of Terminology

Capitated Rate or Pre-Paid Capitated Rate means the payment made to a service provider or manager on a per-capita basis to cover the costs of services for each client enrolled in a program. Payment is made, not for each individual service provided (as in "fee-for-service"), but to cover the provider's or manager's risk of having to serve clients within a certain population. A **pre-paid capitated** program pays the provider up-front allowing it to manage resources and obligations so as to reduce costs and coordinate care.

Care Management Entity means the entity which manages the local integrated service delivery system and integrated fund. It performs the key "integrative functions" and either contracts for the provision of children's mental health services or provides those services itself.

Catchment Area or Service Delivery Area means the geographic area within which children are served by the local integrated system. The catchment area is defined by the local community. It may follow county boundaries or encompass two or more counties. It may follow school district boundaries or the boundaries of a special education cooperative. It may encompass parts of counties or parts of school districts. The determining factor is which agencies want to participate. For example, County "X" wants to participate. Within that county are School Districts "A" and "B". School District "A" wants to join but "B" does not. The catchment area can later be expanded to include School District "B". In the meantime, a decision will have to be made regarding how to address children who are residents of both County "X" and School District "B".

Categorical Services/Funds/Systems means those entities which are designed to serve a particular category of client or category of disability. "Mental health" is a category, as is chemical dependency, child protection, developmental disability, juvenile justice, etc. It is contrasted with "integrated" which suggests coordinating services in order to address all categories of need.

Customized Package of Services means an comprehensive, cross-system approach to service provision in which an interagency and interdisciplinary team, working in conjunction with the child and parents, devises a creative and highly individualized combination of services, supports, and activities -- both innovative and traditional -- to meet the needs of the child and family and, in particular, to improve the child's ability to function in the home, school, and community. A Customized Package of Services is based on a complete assessment of the strengths and needs of the child and family. They are constrained only by the limits of the team's creativity.

Fee-For-Service means that each individual service received carries a fee. It is contrasted with "capitated rate" which pays a service provider or care plan manager for the risk of having to provide an agreed-upon package of services

Flexibility refers to both services and funding sources. It focuses on the latitude that the person sitting face-to-face with a child has to draw from all the necessary resources to meet that child's need. It means the ability to draw from any service that is available from any child-serving organization in the community. It also means the ability to draw from any funding source that pays for any type of service for children with an emotional or behavioral disorder; funding flexibility can be achieved by pulling dollars from the various funding sources into a single pool.

Full Continuum or Full Array of Services means the availability of services necessary to address all levels of an emotional or behavioral disorder, from the earliest indicators of a potential problem to the most severe emotional crisis. The continuum starts with community education and prevention activities, progressing to early identification of a disorder and intervention at that early stage. The intensity of intervention increases until a child needs to be placed in residential treatment or admitted to an acute care psychiatric hospital. In general, the more intensive a service is, the more expensive.

Functionally Integrated means the coordination of the efforts of multiple independent agencies. It is contrasted to "structural integration" which would be the merger of the agencies into a single organization. It focuses on creating mechanisms that change the relationships among agencies so that they can work together around the needs of a particular child. This proposal calls such mechanisms "integrative functions".

Governance Structure means the legal entity created or designated by existing legal authorities -- such as county boards, school boards, and mental health centers -- to establish and supervise the "care management entity". It also serves as the local agent to the state Medical Assistance authority.

Integrated Fund means a pool of local, state, and federal resources, consolidated at the local level, to accomplish locally agreed upon service goals for the target population. The fund would help all child-serving systems to serve the mental health needs of children among their populations.

Integrated Service Delivery System means a coordinated set of functions established by the local children's mental health collaborative for coordinating services and actions across traditional categorical systems and agencies. It must establish an integrated fund and develop a customized package of services for each child. It must produce strong collaboration between professionals and parents in assessing needs of the parents' children and in planning and providing the agreed-upon services.

Integration means the systemic reforms necessary for child-serving agencies to coordinate the efforts each makes on behalf of a individual child. This report refers to the three basic components, or the "triad of integration": service delivery, funding, and information.

Integration Triad refers to the three areas in which integration efforts are taking place: (a) service delivery system integration, pulls the various services used to address a particular class of problem under a single manager in order to make available to a client all necessary services, no matter which agency the client first enters; (b) funding integration, which merges all of the various funding sources that pay for a particular class of services into a single funding source, so that meeting a child's needs does not depend upon the dollars available in any single funding pot; and (c) information systems integration, permits the an exchange of client information, client outcomes evaluation, and interagency program evaluation. Technically, it means creation of common terminology, agreement on the type of information collected, and some means of reporting cross-agency data to state agencies. This report makes the distinction among the three areas because various reform projects have focused their efforts on different combinations of the three. All three corners of the triad must eventually be addressed to create the most flexible system, although significant improvements can be achieved by undertaking one or two areas.

Integrative Functions means those activities which coordinate the efforts of multiple agencies and systems around the needs of a particular child. In this proposal, those integrative functions are: (1) multi-agency intake by parent and professional collaboration; (2) multi-agency assessment coordination; (3) multi-agency care planning; and (4) unitary case management for a customized package of services.

Local Collaborative is a general reference to the collaborative effort undertaken by agencies and individuals in a given community to initiate, plan, implement, and operate an integrated service delivery system and integrated fund. Initially, the Local Collaborative may be those local leaders who begin the efforts to promote interest in the project and gain commitments from other leaders or key agencies. In the next phase, it becomes more concrete: the entity formed by contractual agreement among the players in the local care system in order to begin a formal planning process and to receive state start-up funds and technical assistance. Later it may become the governance structure and/or care management entity. The "Local Coordinating Council" or "Interagency Early Intervention Council" in a community may serve as the Local Collaborative if it is capable.

Managed Care means a system that links fiscal and clinical management to provide negotiated costs and levels of quality. It can take many forms including designated provider networks, pre-paid capitation, managed fee-for-service, utilization review, health maintenance organizations, case management, and others.

Multi-Agency Assessment Coordination means eliminating duplicative clinical assessments and securing assessments which meet the needs of all systems and providing sufficient information for the development of care plans.

Multi-Agency Care Planning means developing plans of care by an interagency, interdisciplinary team from all agencies which are expected to work with the child and/or family. Care plans are based on comprehensive, multi-agency assessment and are developed cooperatively with parent(s).

Multi-Agency Intake by Parent/Professional Collaboration means learning the child's needs from the point-of-view of the family and guiding the family through the integrated system.

Revenue Enhancement means increasing federal dollars coming into Minnesota's children's mental health systems by means of integrating funding sources under the name of mental health in order to create a larger pool of local and state dollars against which to leverage greater federal reimbursement from local and state expenditures. Federal entitlement programs partially reimburse states for expenditures on services that states are mandated by federal law to provide. The reimbursement rates vary by program and by state. Revenue enhancement is technically complex and can involve several different federal programs, each with its own set of rules. Most schemes aim to increase federal revenues without increasing state or local obligations.

Service Provider means the qualified provider of services to children with emotional and/or behavioral disorders. Depending on the system established in a given community, a service provider may be an independent fee-for-service clinician, a preferred provider network, a single-entity managed care provider, or the care management entity of the Integrated System.

State Agency Compact means an agreement among state agencies to coordinate their efforts to assist Local Collaboratives establish Integrated Children's Mental Health Systems and Integrated Funds. The Compact should create or designate an entity to direct all state-level support, including technical assistance and legal changes necessary to proceed with federal revenue enhancement. The Task Force has recommended that the State Coordinating Council, establish by the Comprehensive Children's Mental Health Act, assume this responsibility.

State Coordinating Council (SCC) means that body created by the Comprehensive Children's Mental Health Act to coordinate the development and delivery of children's mental health services at the highest levels of state departments. The commissioners, or designees, of the departments of Human Services, Health, Education, Corrections, and Commerce were appointed to serve in conjunction with the director, or designee, of Minnesota Planning and a representative of the Minnesota District Judges Association Juvenile Committee. The SCC must educate each agency; develop mechanisms for coordination; identify barriers; and identify mechanisms for better use of state and federal funds. The Task Force recommends that the SCC coordinate state-level support for local collaboratives.

Structurally Integrated means the merger of child-serving agencies into a single organization as a means of coordinating the services provided by the various agencies. It is contrasted to "functional integration" which is the coordination of the efforts of multiple independent agencies.

System(s) has two meanings in this report. In its plural form, "categorical systems" usually refers to the various configurations of organizations, missions, practices, and programs set up to serve a particular category of client with a particular category of need -- e.g. the juvenile justice system, the educational system, or the child welfare system. In its singular form, this report uses it to refer to the new "integrated system" that is created through the collaboration of the categorical systems.

Target Population means the particular client group that a program is supposed to help. The target population for this proposal is defined in Section II-B.

Technical Assistance means the guidance provided by state staff and consultants to Local Collaboratives as they establish a local integrated system or a local integrated fund. It refers to interpretation of federal and state laws and rules or the contents of this report. It refers to devising strategies for collaborative efforts and to mediating among local players.

Third-Party Payer means the party that pays for a service. It can refer to a government fund (such as Medical Assistance or MinnesotaCare) or to a private payment plan. In this report, "private third-party payer" refers to an insurance company, a health maintenance organization (HMO), or an employer health plan. The term derives from the reference to the client of the service as the "first party" and the provider (therapist, doctor, etc.) as the "second party". If the client does not pay for his or her own treatment, the payer is then a "third party".

Unitary Case Management means coordinating and arranging services across all systems in partnership with the child and parents. Its function is to execute the individual case plan.

Wrap-Around Services means non-traditional, flexible, and highly individualized services that serve to coordinate and facilitate traditional mental health services and programs. They "fill in the gaps" between traditional services. Wrap around service may include, but are not limited to respite services, services that assist in enrolling or participating in recreational activities, and assisting to purchase otherwise unavailable items or services needed to maintain a child in the family.